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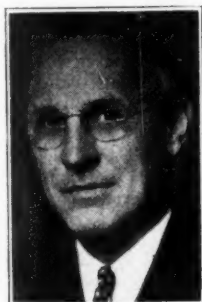
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THE DIAGNOSIS OF PYURIA IN CHILDHOOD AND ITS TREATMENT WITH MANDELIC ACID AND SULFANILAMIDE*

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So much has been written about the frequency of pyuria in childhood that there has been a tendency to make the diagnosis every time a few pus cells are found in a specimen of urine which has been obtained in the usual manner. Pus cells in such a specimen may indicate an infection of the bladder or upper urinary passages; more frequently, however, they are merely evidence that there has been an admixture of pus from the vaginal secretion in the female or slight irritation under the prepuce of the male.

The presence of pus cells in a single specimen of urine passed in the usual manner should never be relied on to make a diagnosis of inflammation of the upper urinary passages. In the female, a catheterized specimen of urine should be obtained from the bladder; this should be examined microscopically for pus, a centrifuged specimen should be stained by Gram's method, and a culture should be made in order to ascertain the type of organism which is causing the infection. In the male, the foreskin should be retracted, the meatus wiped with a little cotton (which has been moistened with sterile water) and, after the patient has passed a few cubic centimeters of urine to wash out the anterior portion of the urethra, the specimen should be caught in a sterile container. In infants, and in the case of uncoöperative older boys, a specimen may be obtained by means of a ureteral catheter. In this way the presence of infection can definitely be determined. Usually pus is found in the

urine, Gram-negative bacilli in the smear and on cultures. If the culture and Gram stain prove to be negative for bacteria and if pus is present, it is likely that the patient is suffering from tuberculosis of the kidney. If the stain is positive and the plate culture negative after twenty-four hours, it is probable that the infection is due to an anaërobe or to some very slow-growing organism. Cultures are made with eosin-methylene blue agar, by means of which it is possible to differentiate between the most common of the Gram-negative bacilli found in the urine. Blood agar is used to differentiate the streptococci.

Until recently, identification of the various so-called Gram-negative bacilli found in urinary infections was not carried out and, as long as the treatment in no way depended upon the particular type of organism that was present, it was not necessary to

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differentiate members of this group. Now that drugs are available which act differently on various organisms, however, and which act only when certain conditions are obtained in the urine, it becomes necessary to know which particular type or types of bacteria are causing the infection. An example of such a drug having a specific action is sulfanilamide. This drug does not affect *Streptococcus faecalis*, however, and is thus useless in the treatment of infections caused by this organism. Another example is the almost insurmountable difficulty of acidifying the urine in infections with *Proteus ammoniæ*, and still another is the great resistance of *Pseudomonas* infection to anti-septic therapy.

A determination of the presence and type of infection must be followed by the determination of the status of renal function and the normality of urinary drainage. There are still too many children who have had their kidneys irreparably damaged by long-continued back pressure and infection before they were referred to a urologist for the relief of stasis. It is the duty of the physician treating infections of the urinary tract to include in his diagnostic program the determination of the renal function and the absence of urinary stasis. Facilities for the determination of the blood urea and for intravenous urograms are now within the reach of private practitioners almost everywhere.

It is very evident, therefore, that the diagnosis of an inflammatory lesion of the urinary passages should rest on more clinical data than the mere finding of some pus cells in the urine and, likewise, a cure on more evidence than a urine free of pus cells. Unfortunately, it is still very common to find the diagnosis based solely on the presence of pus, and the cure on its disappearance from the urine. This all sounds very complicated, but it can be simplified in general practice. Bacteria alone, or with pus, found in a specimen properly obtained can be identified under the low power lens of a microscope, and culture for determination of the sterility of the urine can be very simply made with only a catheter and an agar tube.

Having determined the existence of infection and its nature, and having ascertained that the function of the kidneys and urinary drainage are normal, how does one

proceed with the treatment? It has been my experience that, in the hands of the man in general practice, the simplest mode of treatment is likely to give the best results. It is for this reason that I recommend sulfanilamide. This drug is given in a standard dose per pound of body weight and no attention needs to be paid to the reaction of the urine or to the concentration of the drug except when excessive amounts of fluid are prescribed.

Sulfanilamide acts best in an alkaline urine and it usually produces an alkaline urine by the washing out of alkali. It is, therefore, well to give from 10 to 15 grains (0.65 to 1 gm.) of sodium bicarbonate three times a day with the sulfanilamide in order to prevent acidosis. The dose of sulfanilamide which I have found to be sufficient in most cases is 10 grains (0.65 gm.) per 20 pounds (9 kg.) of body weight; if necessary, the dose may be increased to 15 grains (1 gm.) per 20 pounds of body weight, as recommended by Long in the treatment of streptococcus infection. For short periods the dose may be increased to 20 grains (1.3 gm.) per 20 pounds of body weight. It is possible, further, to increase the urinary concentration without increasing the blood concentration by cutting down on the intake of fluids.

Long has pointed out that cyanosis is of no significance as a toxic manifestation, but a rash, fever and rapid fall in the number of erythrocytes or leukocytes necessitates immediate withdrawal of the drug.

For many years the administration of large amounts of fluids and alkalization of the urine have been the standard treatment in acute cases of pyelitis, especially in infancy. In addition to this routine treatment, sulfanilamide can be given very advantageously every four hours in the dosage just indicated. With the addition of sulfanilamide to the scheme of treatment, the acute symptoms, high fever and restlessness may disappear at an earlier time than usual. Administration of the drug should be continued in the same dosage until a culture of the urine no longer shows evidence of bacterial growth. The frequency with which bacteria return in cases in which administration of the drug is discontinued immediately after the urine becomes sterile indicates the necessity for a longer period of anti-sepsis to cure the patient. The drug should

be given for from four to six days after the urine has become sterile. If, at the end of a week, the urine is still found to be sterile, administration of the drug should be discontinued and an interval of three or four days should be allowed to elapse. Another culture is then taken and if it, too, is sterile, one may be quite certain that the patient has been cured. If, on the other hand, the culture of the urine again shows bacteria, then it must be assumed that bacterial growth in the urine was merely inhibited and that further treatment is necessary. Instead of 10 grains, 15 grains of sulfanilamide per 20 pounds body weight should next be tried and the same process repeated. It is advisable in such cases to continue the same dosage for eight to ten days after first obtaining a sterile urine. Four days after discontinuation of the medication, the urine should again be checked by culture for sterility of the urine. The same procedure is carried out in cases of subacute and chronic infections, with the exception that no effort is made to force fluids.

A rapid recovery from both acute and chronic infections is likely when the infecting organism is any one of the group of Gram-negative bacilli, *Escherichia coli*, *Aerobacter aerogenes*, *Salmonella*, *Proteus vulgaris*, or *Proteus ammoniæ*. The same applies to staphylococcus infection of the lower portion of the urinary tract. Pseudomonas infections are more difficult to cure. The excellent results obtained in treating infections with the bacillus, *Proteus ammoniæ* (encrusted cystitis), should be emphasized because it, in particular, has been resistant to methenamine and mandelic acid as well as to therapy by means of the ketogenic diet. All three of these modes of treatment are dependent upon a strongly acid urine for their bactericidal action, and the highly alkaline nature of the urine in *Proteus* infections prevents this.

When the function of the kidneys has been so reduced in chronic pyelonephritis that the value for blood urea has risen above 50 mg. per cent, the kidneys are usually unable to excrete urine of low pH. The same situation may arise when only one kidney is affected. The normal kidney is able to excrete urine of low pH with definite bactericidal power, whereas the affected kidney secretes a urine of higher pH without bactericidal power. It was very helpful to discover that sulfanilamide is secreted in

bactericidal concentrations in the urine of patients who had values for blood urea varying from 50 to 100 mg. per cent. In four of five such cases the urine was sterile, although only temporarily so. Such a result I had never achieved with any other drug. The concentration of free sulfanilamide in the urine never rose above 25 mg. per cent in these cases and yet a sterile urine was obtained in four of the five cases. Great care must be exercised in the treatment of this group of patients because the inability of the kidneys to secrete sulfanilamide at the normal rate may result in the drug accumulating in the blood and producing toxic symptoms.

So far I have reported only the advantages of treatment by means of sulfanilamide. Its one great drawback, however, is its ineffectiveness in treating infections caused by *Streptococcus faecalis*. This streptococcus seems to grow luxuriantly in concentrations of sulfanilamide which will rapidly kill off bacilli of the Gram-negative group.

Since I have used sulfanilamide it has become evident that *Streptococcus faecalis* is a much more frequent invader of the urinary passages than I had formerly realized. I have found, on a number of occasions, that a patient with pyelitis, apparently a pure *Escherichia coli* infection, was rapidly rid of this organism by means of sulfanilamide, only to find that the urine, on culture, then contained innumerable organisms of *Streptococcus faecalis*. I found, in looking over old charts of patients infected with *Escherichia coli* who had been successfully treated with methenamine, the ketogenic diet, or mandelic acid, that it was not unusual, on culturing the urine, to find a few colonies of *Streptococcus faecalis* on the agar plates after the *Escherichia coli* had completely disappeared. The continuation of treatment usually resulted in the disappearance of these streptococci also. This would indicate that *Streptococcus faecalis* does not grow in urine containing formaldehyde or organic acids as it does in urine containing sulfanilamide, and that it is more resistant to treatment than the colon bacillus but can eventually be killed off when treatment is persisted in. How frequently mixed infections occur should become evident with the continued use of sulfanilamide. If there are many, the success of sulfanilamide therapy

will be decreased, and this will necessitate treatment by means of a combination of sulfanilamide and mandelic acid.

Organic acid therapy was introduced in the form of the ketogenic diet. More successful than any previously used method of treatment, the difficulties of taking the diet were, nevertheless, such that, when Rosenheim showed that mandelic acid would act just as successfully as beta-oxybutyric acid in the cure of urinary infections, mandelic acid entirely replaced the diet.

Mandelic acid acts bactericidally in a urine of a pH below 5.5 and at a concentration greater than 0.5 per cent. Whenever these conditions can be attained, it is possible to clear up infections caused by any of the usual organisms which are found in pyogenic infections of the urinary passages with the exception of the tubercle bacillus. The fact that these two conditions are necessary in order to obtain bactericidal action makes the treatment somewhat more difficult. However, in view of the fact that the acidification of the urine and the concentration of mandelate in the urine is usually sufficient when ammonium mandelate or calcium mandelate is given in a dose of 1 gm. per day for every 100 c.c. of urinary output in twenty-four hours, it is usually possible to attain a good therapeutic result without further testing of the conditions of the urine. It is preferable to test the pH of the urine with nitrazine paper to make sure that it is below 5.5. If necessary, ammonium nitrate (0.5 gm. four times a day) may be given in addition if the acidity is not great enough. The excretion of mandelate is almost entirely by the kidney, so that a dose of 1 gm. per 100 c.c. of urinary output practically assures a concentration more than 0.5 per cent. The usual adult dose of 45 grains (3 gm.) four times a day is given to children from twelve to fifteen years of age. Infants can take 10 grains (0.65 gm.) four times a day and, depending on urinary output, a gradually increasing dose with age up to the adult dose.

In the treatment of urinary infections by means of mandelic acid, the following procedure is of advantage: On many occasions I have seen a sterile culture obtained from the urine twenty-four hours after starting treatment. It is advisable to continue treatment for three or four days after the urine has become sterile as tested by culture. Administration of the drug may then be discontinued and, after another interval of

three or four days, culture repeated; a sterile culture then indicates cure. The drug is not very palatable, and the ammonium salt cannot be easily disguised by any other flavor. The calcium salt is somewhat bitter but not particularly unpleasant. When the little patient will not take the drug, or cannot take it by mouth because of nausea and vomiting, it may be administered in suppository form in exactly the same dose.

Failures with mandelic acid therapy occur in cases in which the function of the kidney is lowered and in which the necessary acidity of the urine cannot be reached. A recent patient, whose blood urea was 38 mg. per cent, was cured of a colon bacillus infection by the use of sulfanilamide, only to have *Streptococcus faecalis* appear, which could not be cleared up with mandelic acid because the pH of the urine could never be reduced to the bactericidal level. This may apply to one or both kidneys. In cases of infection with *Proteus ammoniae* in which the alkaline reaction persists regardless of the giving of acid salts, the bactericidal range can never be reached. Fortunately, such cases are rare in infancy and childhood.

Treatment by means of sulfanilamide is, as has been indicated, easier to carry out than is treatment by the ketogenic diet, methenamine, or mandelic acid. It is successful in urine which is alkaline because of urea-splitting organisms, and it is successful in conditions in which the function of the kidney is reduced. Sulfanilamide, as has been said, is of no value in the treatment of infections with *Streptococcus faecalis*. Mandelic acid is of value in the treatment of all infections in which the urinary acidity can be reduced below 5.5 and the drug excreted in a concentration in 0.5 per cent.

In conclusion, I wish to emphasize the duty of the physician in determining the absence of stasis in the urinary passages before dismissing any patient he has been treating for infection of the urinary tract. Markedly lowered renal function is the one condition which prevents successful treatment, and only if infection and back pressure are recognized early will it be possible to prevent damage to the kidneys. An excretory urogram and a culture of the urine will tell the story. Closer coöperation between pediatricians and general practitioners and the urologist will save many deaths in later life from renal insufficiency.

TREATMENT OF IMPOTENCE

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Impotence is the inability to perform the sexual act. It is a very common disturbance and one which often causes the urologist deep concern. The causes are roughly divisible into two groups: (1) Organic; (2) Psychogenic. This classification is not as valid as it may seem on the surface, for very often there is a blending of the two elements. A man suffering with impotence due to an organic lesion may appear to have a psychic disorder. Likewise—as is more often the case—a man with psychic impotence may simulate true or organic impotency. Also, psychic and organic factors may operate simultaneously. In men between the ages of twenty and forty, impotence, more generally, is due to a disturbance in the psychic system than to an anatomic defect in the genitalia.

By the use of the term impotence we do not merely imply that there exists a condition of partial or incomplete erection. The inability to display or perceive the various manifestations which characterize physiological coitus, denotes a state of impotency of greater or lesser degree. We recognize the stages of copulation as: (1) The stage of sexual excitement or the pre-copulatory phase; (2) The stage of increased glandular activity; (3) Erection; (4) Introduction of the phallus; (5) Frictional movement; (6) Existence of voluptuous or pleasurable sensation; (7) The orgasm; (8) Ejaculation; (9) Detumescence, or the return of the erect organ to a state of flaccidity.

Erection is that physical state essential for the introduction of the phallus. It is essentially a process of hyperemia. The influx of arterial blood is augmented by heightened blood pressure and complete vaso-dilatation. Outflow of blood is prevented by a process of venous constriction. Physiologists and anatomists have given their best efforts to solve the mystery of how blood is retained within the erectile bodies. Every sort of explanation has been offered. One theory that has gained considerable credence is that there exist special valves within the penile veins known as funnel valves which supposedly only function during sexual excitement and serve as complete barriers to the egress of blood. Time and again, attempts have been made to demonstrate special muscles within the veins which serve as vaso-constrictors. Anatomists have also tried to prove that the uro-

genital diaphragm is capable of blocking the outflow of blood. None of these explanations has been fortified by scientific proof.

One of the first clues to the physiology of erection was furnished by the experiment popularly known to medical students of yesteryear as the "wassersteife." This consisted of placing a firm rubber band around the base of a cadaver penis and injecting water into the deep dorsal penile vein until the penis became firm and erect. While it is true that the penis of the cadaver may be made firm and erect in this manner, it does not follow that this is the process which is enacted in life. There is considerable evidence to show that it certainly is not the physiological *modus operandi*. In any number of instances the deep and superficial dorsal veins have been ligated with the hope of producing erection by passive congestion. All such surgical efforts have ended in failure.

It is my belief that blood is retained within the erectile bodies in sufficient volume to maintain organ turgidity, by the mechanical distension of the trabeculae against the venous draining system. The arterial inflow is so voluminous and so sudden that the veins are temporarily choked off by the distended blood spaces. Rigidity of the penis is due to the increased blood pressure within the penile arteries and the resultant distension by the inflowing blood against the firm tunics and fascial coverings of the erectile bodies. Elevation of the penis is effected partly by the suspensory ligament of the penis and to the anatomic fact that the dorsal surface of the penis is shorter than the ventral surface. The erector muscles aid in the process and also serve to stabilize the erection.

A wide variety of stimuli may generate erection:

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1. Local stimulation of the sensitive nerve endings of the glans penis may induce erection. This may be a simple reflex process, independent of the higher cerebral centers.

2. Psychogenic erection resulting from phantasied images, or from previous impressions.

3. Sensory impulses emanating from the organs of special sense are, undoubtedly, the usual mode of arousal. Stimulation from the libidinal zones serves to augment the intensity of the process. Emotional stimuli are conveyed to the sexual centers in the brain, from whence they pass through the extrapyramidal tracts to the centers regulating the sympathetic system. Concomitantly, impulses are carried to the erector centers in the lumbar and sacral segments of the cord to the hypogastric plexus. From these sites impulses pass to the corpora cavernosa.

4. Organ reflexes may generate erection. Over-distended seminal vesicles or a congested prostate, by pressure effects against their sympathetic innervation, may induce a hyperemic state of the erectile bodies. Irritation of the veru can readily induce an erection, a phenomenon often noted when silver nitrate is applied to the posterior urethra.

5. Indirect pressure of the accessory sexual glands by a distended bladder is the explanation offered for the common morning erection which usually vanishes on emptying the urinary bladder.

6. Pathologic erection due to chronic degenerative processes. This type of erection is seen in cases of leukemia; severe forms of uremia; thrombus of the vessels draining the corpora cavernosa; tabes and neoplasm of the lower cord.

7. Cerebral irritation induced by tumors of the pineal body is a condition rarely encountered.

8. Erection may be due to the irritant action of drugs such as follows the ingestion of cantharides or yohimbin.

The organic causes of impotency are classified in the following groups: (1) Congenital deformities; (2) Endocrine disorders; (3) Diseases of the central nervous system; (4) Debilitating disorders; (5) Local causes.

For the sake of academic completeness, I shall list the main congenital disabilities,

though most of them are extremely rare. These defects are: Absence of penis; abnormally small organ; absence of glans penis; absence of erectile bodies; synechia of penis to scrotum; an accessory urethra; unformed urethra; epispadias; hypospadias; congenital fistula of the urethra; congenital stricture of the urethra; ectopia of the bladder; pseudohermaphrodisim; hermaphrodisim; double penis; bone in the penis; short frænum; urethral valves.

Ever since the year 1889, when Brown-Séquard injected into himself a dilute and crude extract of testes, the subject of endocrine influence in sexual potency has been gaining in importance. To recall the facts of this celebrated experiment, Brown-Séquard injected into himself 1 c.c. of testicular extract daily for a period of two weeks. The improvement lasted for a month. He noticed that he felt less fatigue and in a certain sense experienced a feeling of rejuvenation. However, he admitted that suggestion probably played a considerable part in the improvement.

Decreased action of the thyroid, associated with a lowered basal metabolism, may lower sexual vitality. Hyperpituitarism (acromegaly) may be responsible for loss of sexual power. More frequently, one sees cases of hypopituitarism (Fröhlich's syndrome), a condition characterized by abnormal deposits of fat and an infantile-sized penis and testes. Impotency is also associated with eunuchoidism and infantilism.

Decreased sexual potency may be due to organic lesions of the central nervous system. Principally these affections are: injury to the brain and spinal cord; cerebral hemorrhage, thrombosis or embolism; cysts or tumors of the brain; lethargic encephalitis; meningitis; multiple sclerosis; myelitis; progressive paralysis; premature arteriosclerosis; paralysis agitans; cerebrospinal syphilis and tabes. In several of these afflictions priapism may precede impotency.

Habitual use of certain drugs may lessen the libido. Morphine or one of its derivatives is a powerful depressant of the sexualis. Addiction to acetanilid or phenobarbital may definitely curb the sexual ardor. Beer, wine or spiritus frumenti in moderate quantities act in most individuals as a tonic and serve to stabilize the sexual integrity. I particularly caution against the use of most home brew concoctions. Dur-

ing the period of prohibition, I saw several cases of genital disorder which were traceable to the poisonous action of improperly made alcoholic beverages.

The local causes of impotency are most familiar to urologists and are the ones which are most amenable to treatment. These are: congenital phimosis; short frænum; pin-point meatus; prostatitis; seminal vesiculitis; verumontanitis; benign tumors of the veru; stricture of the anterior or posterior urethra; pathologic growths on the glans penis; bladder, prostatic, and urethral stone. Among the more severe local causes of impotency there are: induratio penis plastica; varicocele, hydrocele or hematocele which interfere with introduction of the phallus; gangrene of the penis; traumatized perineum resulting from gunshot or injury; fracture of the penis; the end-result of prostatectomy.

Debilitating diseases such as pernicious anemia, severe secondary anemia; nephritis, arteriosclerosis, gout, diabetes mellitus and insipidus, cachexia, diseases due to vitamin deficiency, typhoid fever and influenza may undermine the erectile power. The toxins may exert their action on the endocrine organs or on the genital nerve plexuses.

Coitus interruptus, commonly known as withdrawal, often does considerable harm to the sexual apparatus. This unphysiological method of prevention induces prostatitis, seminal vesiculitis and verumontanitis, which in turn upset the normal neuro-muscular mechanism which operates in sustaining erection. If this practice is indulged over a period of many years, it is apt to lead to atony of the genital musculature. Coitus prolongatus may have an injurious effect on the prostate. Coitus reservatus—the act of performing coitus without ejaculating—may have a deleterious effect.

Correction of inadequate erection due to organic causes is obtained by medical and surgical measures. I will frankly state that I do not use nor have much confidence in the popular aphrodisiacs. The ineffectiveness of this group of drugs impressed itself on me many years ago, since which time I discontinued prescribing them.

When definite signs exist that the thyroid gland is over- or under-functioning, I use the appropriate medication. Men with a very low basal metabolism often experience

a return of vitality when their metabolic rate is increased to a normal level.

The injection of male sex hormones has received wide application. Since Berthold in 1849 offered scientific proof that the testicles control the size of cockerel combs, an overwhelming amount of research has been done along these lines. In experimental animals, it has been shown that injection of androgen substances will increase skeletal growth, improve muscular tone, raise the metabolic rate, elevate the hemoglobin and oxidase content of the blood and tissues, and control the development of secondary sexual characteristics as well as the accessory reproductive organs. In humans, we do not know as yet just what usefulness these substances have in the treatment of impotence. In cases where there is definite evidence that the subject suffers from lack of male hormone, it is likely that therapeutic success may be achieved. Pituitary hormone is of definite value in impotency associated with the Fröhlich syndrome.

My most striking results in organic impotency are obtained by employing orthodox urological measures in cases of prostatitis, seminal vesiculitis and stricture of the urethra. Evacuation of stagnant secretion contained within the accessory sexual glands, stretching of scar tissue along the urethra or clearing up a cystitis due to post-gonorrhea infection or a non-specific infection, are measures which have brought spectacular results.

Surgical procedures are definitely indicated in instances where there exists a pin-point meatus, a long adherent foreskin, valves in the urethra, hydrocele, hematocele or warty excrescences on the glans penis. Recently, I saw a case of impotency for which the patient had received considerable treatment. On examination, I found that he had a tiny meatus, and without any hesitation I injected some local anesthetic and performed a meatotomy. Two days later, I examined the bladder and urethra with a cystourethroscope and found that he had a moderate-sized papillomatous growth on the edge of the trigone which floated back and forth within the internal urethral orifice. The subject of impotency immediately faded out of the picture and the neoplasm was attended to. What I am emphasizing is that no man should be treated for lessened sexual power unless

he has had the benefit of a cystoscopic and urethroscopic examination. On one occasion, I found a bladder stone which was keeping up an inflamed posterior urethra by periodically rolling back and forth and making urination painful and coitus impossible.

Ligation of the superficial and deep dorsal penile veins has no appreciable effect on the erectile power. A physician recently asked me to perform this operation on himself. He felt certain that it would help him because, as he stated, "when I grasp the base of the penis and compress the vein, an erection ensues." In compliance with his request, I ligated the superficial vein and, as I prophesied, no visible effect ensued. The causative factors—stricture of the posterior urethra and an accompanying seminal vesiculitis—are now being treated.

Awakening of lost sexual power by the alleged rejuvenation operations of Steinach have been loudly advocated. Years ago, when surgeons treated prostatic enlargement by vasoligation, no one made mention of any rejuvenating effects brought about by this procedure. It is only since prostatectomy was practiced that vasoligation seems to have benefited the fading power of aging men. In my opinion, tying off the vas brings about a feeling of rejuvenescence in only those cases where there exists a stagnation within the seminal vesicles. Some cases of chronic vesiculitis are cured in this manner and the improvement is attributed to an increased activity of the interstitial cells of Leydig.

Gland transplantation, which was inaugurated by Lydston, agitated the public as well as the profession for several years, but produced no tangible results. This spectacular procedure has, I believe, seen its heyday.

Concerning the use of mechanical contraptions to insure erection, I can only say that I have yet to hear a favorable report from one who has used such a contrivance.

Recently, Lowsley introduced an operation which consists in shortening the bulbo—and ischio-cavernosi muscles. In a selected group, the early results were favorable in a fair proportion of cases. Sufficient time has not yet elapsed to estimate the permanency of the improvement.

Psychic Impotency

Sexual disorders which we now classify as psychic impotency were formerly regarded as end-results of physical defects. That prevalent disorder, premature ejaculation, was treated on the basis that pathological changes were responsible for this weakness. Since we have regarded ejaculatio præcox from the psychopathologic viewpoint, much progress has been made in the amelioration of this embarrassing ailment. While some physical elements play a part in the so-called functional derangements, the main disturbance is within the psychic sphere.

A comprehensive understanding concerning the genesis of sexual fear is essential to the proper management of psychic impotency. Practically all individuals are dominated to a greater or lesser extent by sexual fear during their developmental period. Dread of things sexual is dissipated gradually on reaching maturity. Our civilization, by its rigid moral tenets, tends to inculcate an abnormal fear of the sexual component of life. Many children are frightened in their teens about sexual matters and these unpleasant memories lie dormant in their unconscious minds ready to dampen their sexual ardor when it blooms into fruition.

Most youths on first experiencing nocturnal emissions (pollutions) believe that this activity is due to impurity in thought. By the dissemination of sexual hygiene information, we have tried to make known to the immature lad that there is nothing sinful in this natural process, which is merely an indication that sexual maturity has begun.

Our energies in this direction have been thwarted by the vast amount of literature which somehow or another finds its way to those who are perplexed by sexual problems. Nor has all this literature emanated from quack sources. Practically every home library has its antiquated home medical adviser, which usually contains a chapter on the evils to which the flesh is heir. These accounts are quite harrowing, particularly those which stress the penalty for indulgence in masturbation. Many other sources of scare literature exist, all of which tend to depress the lad who needs help.

A second cause of sexual fear is due to the *Cædipus-complex*, a condition developed by love rivalry in the home. The condi-

tion implies a too firm attachment of a son to his mother, so that the mature male has a difficult time diverting his attention to a feminine sexual object other than his mother.

Castration complex, or the fear of losing one's sexuality by sexual indulgence, is an unconscious psychic factor that operates to ingrain fear. Often, little boys are told that their sexual organ will wither or drop off if they touch the penis for improper purposes.

Frustration of normal sex activity often results from false education and teaching that normal sexual activity is bestial. Those who have been overly impressed with this thought that the sexual function is degrading have a difficult time in properly asserting their male characteristic at the proper time.

Recognition of psychic impotency is usually not an easy matter. The subject may complain of vague pains in the penis, urethra, prostate, bladder, perineum or scrotum. He may think that his organ is too large or too small; that the veins on or within the scrotum are too large; that an unusually strong odor emanates from his genitalia; or that a small quantity of mucoid discharge from his meatus is the underlying cause of his sexual weakness. When the urologist's attention is directed toward the genitalia, the recognition of sexual neurosis is relatively simple.

In this short paper, I can merely hint at some of the other manifestations of psychological impotence. The symptoms are out of all proportion to the supposed causative factor. Intense emotional upset is associated with the symptom-complex which is presented. Vague neurotic pains are complained of. These are of shifting character. The subject shows indications of a marked feeling of inferiority.

The physiology of the sexual neuroses is difficult to comprehend because it is so intimately related to the complicated sympathetic nervous system, the workings of which are just becoming intelligible to us. One might compare the state of sexual fear to that of stage fright. The speaker who is dominated by fear is embarrassed and is unable to use his organs as he normally would. He perspires and loses all control. Merely standing up before an audience induces a state of physical instability. The

heart beats rapidly and self-possession is lost. Mosso, the Italian physiologist, and Crile, the surgeon physiologist, have emphasized the relation of fear to organ derangement. Sexual fright can deflect the course of blood just as ordinary fright, which explains why those individuals who are unduly sensitive to emotional disturbances may lose their potency at the most inopportune moment.

The various psychological schools present interesting theories concerning the causative factors which lay the foundation for the development of psychic impotency. Freud considers the incest barrier as the psychic deterrent to normal expression in *ejaculatio præcox*. Abraham believes that the precipitate emission of semen is the male's mode of expressing disgust. Stekel regards this form of sexual weakness as an indication that the sexual inhibiting forces are stronger than the aggressive urge. The school of individual psychology states that sexual incompetency is the end-product of guilt feelings. My view is that it results from various types of fear which in turn induce involuntary contractions of the ejaculatory musculature.

Frigidity can induce a state of impotence. The female may display an infantile attitude toward sex by such signs as vaginismus, genital hyperesthesia, hypersensitivity or apparent indifference. All these conditions act as barriers to coitus. It may be caused by psychic trauma, an asocial attitude, or be a symptom of anxiety or a dislike of copulation on moral or esthetic grounds. Without the display of impulsiveness on the part of the female, there will be little reciprocal stimulation in the male.

One of the reasons for the slow permeation of sexual psychology into the several regular departments of medicine, and urology in particular, is due to the dense screen of almost incomprehensible terminology which the psychologists use to define the sexual activity of man. To Adler we owe a debt for the simplification of complex and involved theories and to the psychobiologists for their commonsense, everyday English which they employ in defining abnormal states of being. Quibbling among the various schools of psychology has tended to create a language which even adherents have difficulty in understanding. The term "libido" means one thing to one group and

something else to another. Everything that transpires in the psychic world can be made intelligible to the practitioner with the average I. Q.

To uncover the etiological factors of a sex neurosis or a case of impotence, we first must obtain a good history. The mode of history taking is entirely different from that employed in a urological examination. Urologists, after a quick survey of the early diseases of childhood and the like, proceed to inquire into the localization of pain, urinary frequency, venereal history and the like. A form history is of no value in cases of impotence. Every phase of the individual's life is considered. One should merely request the patient to talk about himself and at first the physician's task is merely to listen. At the same time he must keep his ears open for points which appear to have a bearing on the development of the malady. If the patient is permitted to talk himself out, so to speak, he will ultimately uncover sources of repressed material. During the first few sessions, the patient will present a plausible tale, and will make every effort to show his weaknesses in their best light. As the resistance of the patient wears away, he will become more confidential and will unearth his inner secrets. A seemingly true initial confession may merely be the revelation of the upper strata of a troubled conscience.

When the confidence of the diffident male has been completely won, the physician begins to interject queries which will open up new vistas of thought. At length a prospectus of the patient's social and sexual life will have been unfolded.

This unburdening process has a marked beneficial effect. Our next procedure is to discuss frankly the pet worries of the patient so as to wash away the fears which have beset him and have served to deflect his amatory assertiveness. Masturbation is but one of a long list of so-called sins

which engender a guilty conscience. One cannot dismiss the masturbation bogey by merely brushing the matter lightly aside. By sound logic, we must show the patient that the evils which he attributes to evil indulgence have not injured his sexual constitution. It is the fear of consequences attendant upon self-gratification which causes so much harm.

The ignorance of the average man in sexual matters is appalling. No one knows this better than the urologist. We must give them knowledge in a deft and inoffensive manner. These patients are extremely sensitive about their disability and must not be offended. Once the trick is learned of coaxing the patient to repose the utmost confidence in his physician, the most involved cases can be unraveled and cure is obtainable.

In many instances, we must alter the pattern of the patient's life. This is accomplished by the employment of psychobiological principles. The designation "psychobiology" pertains to the utilization of any aid which the several branches of medicine may offer, as well as that knowledge which is obtainable from the sciences or arts. There are no rigid rules which must be adhered to. The scope is broad and elastic. By the use of suitable measures, an asocial man may evolve into a social person and thus an asexual male can be converted into a sexual being.

An air of hopelessness envelops practically all patients with psychic impotency. Physicians unfamiliar with the sordid viewpoint of the impotent will be overwhelmed, at first, with the patients' depressive attitude and tone of despair. To listen to their tales is at times wearying, and I can assure you that the management of a single case of impotency may entail more grief than several major urological operations. If, in the end, we manage to save a man's life and his respect, it will be time well spent.

THE TREATMENT OF COMPOUND INJURIES WITH PARTICULAR REFERENCE TO THE HAND*

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Rather than read a formal paper and without wishing to make dogmatic and absolute statements I would like to discuss with you in a very informal way the broad problem of treatment of injuries, and in a little more detail the treatment of injuries of the hand. Needless to say, the surgical principles involved are identical, whether the injury involves the hand or some other part of the body.

A word should be said at the outset concerning first aid. Much commendable and worthwhile effort has been exerted to inform the layman concerning the problems of medicine and surgery, but the advice given is sometimes confusing and based on illogical premises. If I could say in a few words what would seem to me ideal first aid treatment it would be:

(1) Expose the open wound widely, if necessary by cutting away the clothing around it. (2) Cover the wound with a sterile dressing. (3) Bandage it snugly to stop bleeding. (4) Immobilize the part by the simplest method available. (5) Get the patient to the doctor immediately. In other words protect the wound, but *leave it alone*.

From that time on the care of the wound becomes the surgeon's problem. His first responsibility is to determine as completely as possible the extent of injury, not by an examination of the wound, but of the patient. There seems to be an overwhelming urge on the part of the unthinking individual to examine the wound, to probe it or to put tension on injured structures. He must convince himself by seeing and feeling torn tissues that an injury has actually been sustained. The thoughtful surgeon knows that such examination is a waste of time, causes suffering and pain and rarely gives helpful information because of the distortion and discoloration of all the tissues involved.

The questions one can usually answer with certainty from an examination of the patient are:

(1) Has there been a fracture? (2) Has there been a nerve injury? (3) Has there been a tendon injury?

To elicit the presence of sensation in the area of median nerve distribution, for ex-

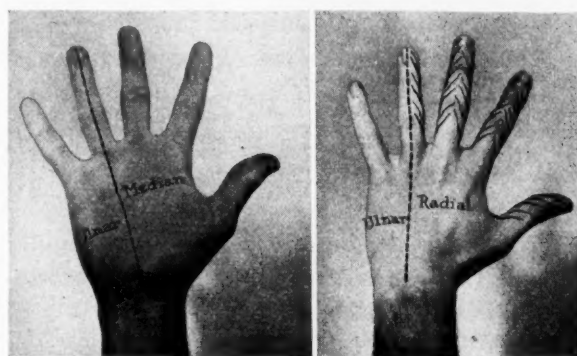


Fig. 1. The sensory distribution of the median, ulnar, and radial nerves in the hand. Loss of sense of pain and touch indicates that there has been a crushing, tearing, or division of the nerve supplying the affected area. (Surg., Gynec. & Obst., 52:594, 1931.)

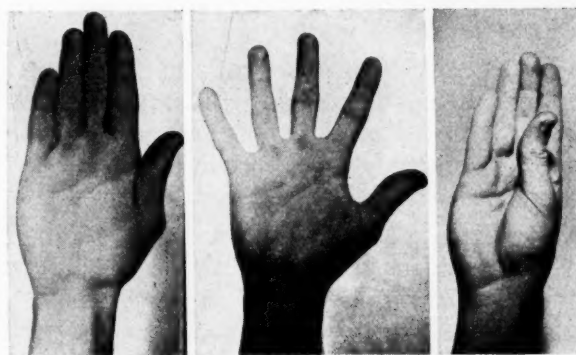


Fig. 2. Adduction of the fingers toward the middle finger (a), abduction of the fingers from the middle finger (b), and abduction of the thumb toward the hand (c) are carried out by the interossei, the muscles of the hypothenar eminence and the adductor pollicis, all of which are supplied by the ulnar nerve. (Surg., Gynec. & Obst., 52:595, 1931.)

ample, requires but a moment, but no amount of probing of a penetrating wound will give exact information as to the presence or extent of such an injury (Figs. 1, 3).

Having determined the extent of injury, the next problem is care of the wound. The question as to the best method is a controversial one, but these facts, based on a

*From the Department of Surgery, Northwestern University Medical School. Read before the Wayne County Medical Society, Detroit, Michigan, March 14, 1938.

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considerable experience, seem to me incontrovertible:

1. Injuries are often more serious than the hasty examiner suspects.

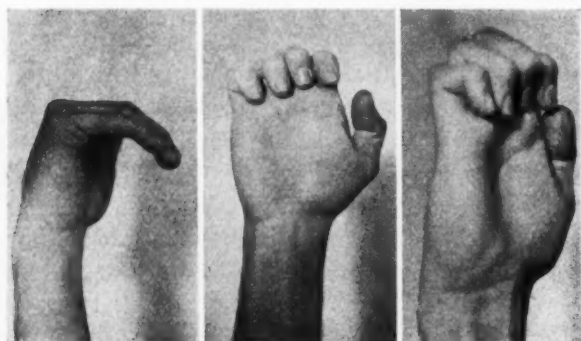


Fig. 3. (a) Flexion at the metacarpophalangeal joints is produced by the lumbricals and interossei. (b and c) With injury or division of the median and ulnar nerves below the middle of the forearm the power of flexion at the metacarpophalangeal joints is lost; the finger can still be flexed at the interphalangeal joints by the long flexor tendons. (Surg., Gynec. & Obst., 52:595, 1931.)

2. Failure to prepare a sufficiently wide area about the site of injury and inadequate assistance often make it difficult to maintain good technic.

3. A patient who suffers pain is difficult to control. Particularly when an extremity is involved he may make some sudden movement that completely nullifies one's efforts to maintain a sterile field and to do accurate surgical work.

4. Repair of injuries of the extremity requires a bloodless field; and maintenance of the required constricting pressure of 250 mm. of mercury soon becomes extremely painful for the average patient.

For these reasons we have come to adopt the following routine for all cases in which more than a simple cutting injury of superficial tissues has occurred. When the examination is completed the patient is sent to the operating room, the blood pressure cuff which is to serve as a constrictor is applied and an anesthetic given. Nitrous oxide or ethylene is preferred. The member of the operating team who first finishes scrubbing his own hands prepares the field of operation. After putting on sterile gloves he washes a wide area about the site of injury with soft cotton, plain white soap and sterile water. The dressing over the wound is undisturbed until the area about the wound is cleansed. Then the dressing is removed and the wound itself carefully cleansed with soap and water until we are

satisfied that it is as clean as it is possible to make it. If bleeding begins when cleansing of the wound is begun the arm is held up for a moment or two and the blood

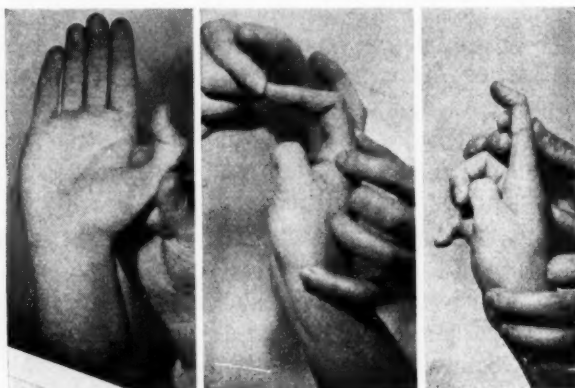


Fig. 4. (a) If the proximal phalanx of the thumb is held fixed, active flexion at the interphalangeal joint is due solely to the contraction of the flexor pollicis longus. If tendon is divided the thumb remains in extension. (b) After division of the flexor profundus; flexion at the proximal interphalangeal joint is possible if the flexor sublimis is still intact, but the finger remains extended at the distal interphalangeal joint. (c) If the flexor profundus is intact the finger can be flexed at the distal interphalangeal joint. (Surg., Gynec. & Obst., 52:595, 1931.)

pressure cuff inflated. The soapy solution is finally washed away with a generous amount of sterile salt solution.

After the sterile linen has been arranged the operative procedure indicated is carried out. The ideal we constantly strive for is primary repair and closure of the wound. This is not always possible or wise; but it is my belief that if a patient is seen immediately after an injury has been sustained, if the wound is not the result of a crushing injury, and if there has not been extensive loss of covering tissue, it is usually possible by patience, careful cleansing and gentle handling of tissue to convert a contaminated wound into a clean wound, to repair the injured structures and close the wound (Fig. 6).

Each of the conditions mentioned is important. An open wound left untreated remains a contaminated wound for a few hours only. As bacteria invade the tissues the stage of infection develops. When infection has begun, any operative procedure beyond cleansing of the surface carries with it the risk of spreading infection widely and rapidly. Secondly, severe crushing wounds are not susceptible of immediate repair, for it is often impossible to determine the extent of tissue damage at the first examination. Careful wound cleansing,

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with immobilization and watchful waiting, is less likely to prove disappointing than the attempt to repair tissues whose vitality is in question. Thirdly, if the covering tis-

procedure. It is better first to secure closure of the wound, and when that objective has been accomplished to repair the deeper tissues.



Fig. 5. (a) "Drop wrist" of musculospiral or radial nerve injury. (b) Loss of power of extension of the fingers due to injury or division of the extensor communis digitorum. (c) With the proximal phalanges supported, the fingers can be extended by the action of the lumbricals and interossei even though the common extensor is divided. (d) Loss of power of extension at the distal interphalangeal joint due to division of the extensor tendon opposite the joint or avulsion of the tendon from its insertion on the distal phalanx. (Surg., Gynec. & Obst., 52:596, 1931.)

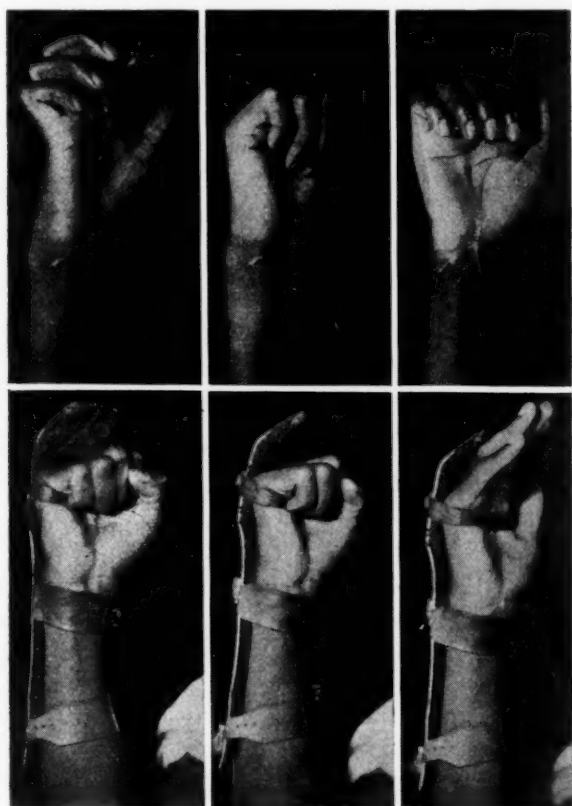


Fig. 6. Result of immediate repair of injury which had caused complete division of median and ulnar nerves and of all the long flexor tendons of fingers and wrist. This patient wore the splint pictured constantly for a year after injury so as to avoid tension upon the lumbrical and interosseous muscles while regeneration of the divided nerves was taking place.

sues have been lost as the result of avulsion or a shearing injury it is unwise to attempt repair of deeper structures, and then cover the open wound with grafts or by a plastic

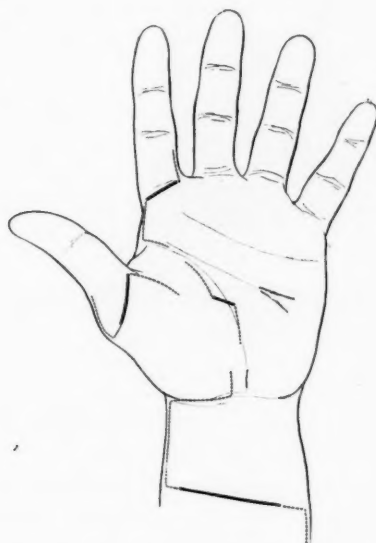


Fig. 7. Incisions (dotted lines) for securing adequate exposure of injured structures. Solid black lines represent wounds of common occurrence. Incisions should not be made across the wound which has resulted from the injury.

It is hardly necessary to emphasize the fact that unless one is willing to exert every possible effort to cleanse the contaminated wound, to avoid trauma, and to carry out repair of injured tissues and closure of the wound with exacting care, it would be far better simply to cleanse the wound, immobilize the part, and permit healing to take place as rapidly as possible. Excellent results can still be obtained by repair after wound healing has taken place, but no

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amount of surgical judgment or skill can compensate for the destructive and crippling effect of the infection which can so easily result from inadequate or indifferent treat-

constriction of the blood pressure cuff is then released to make certain that no active bleeding is present. When bleeding is arrested the pressure is reapplied and contin-

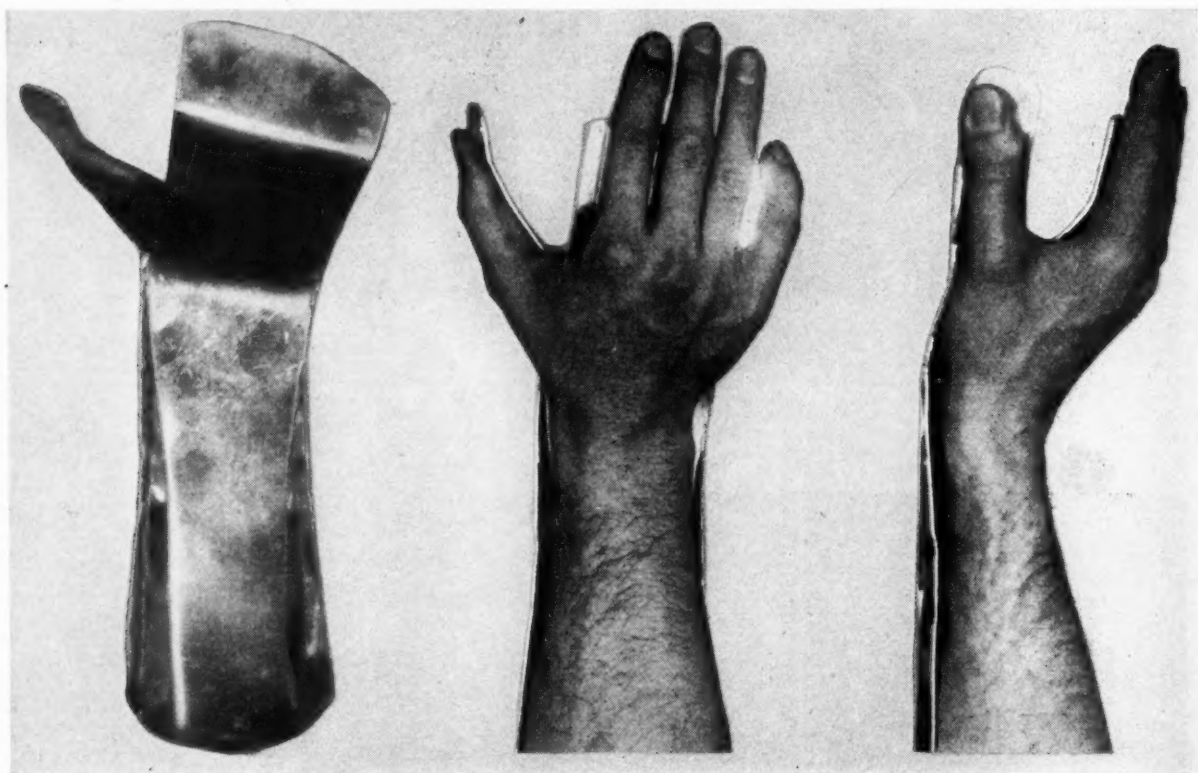


Fig. 8. Aluminum splint for maintaining hand and fingers in the position of function. It can be sterilized and incorporated in the dressings during the stage of acute inflammation; it can be covered with felt and provided with straps for easy application and removal during the stage of convalescence. (*Internat. Abstr. Surg., Surg., Gynec. & Obst.*, p. 106, (Feb. 1) 1938.)

ment immediately after an injury has been sustained.

It is often necessary to enlarge the original wound to secure adequate exposure of injured tissues (Fig. 7). A transverse cut across a finger or across the wrist can be extended proximally from one side and distally from the other, and so permit wide exposure by a simple extension of the original wound. A median incision over finger or wrist always leads to flexion contracture. If the surgeon's incision crosses the wound of injury transversely it makes wound healing by primary union difficult of achievement.

It is not necessary to discuss the exact technic of fracture reduction, of tendon repair and of nerve suture. I would simply say that when repair of the deeper tissues is to be carried out the structures affected are first identified and isolated so that one knows exactly what needs to be done. The

used until wound closure is complete and the pressure dressing applied.

In repairing tendons we handle them gently, put tension on them only with moist gauze, and suture them with silk. Nerves are handled with the same care, and suture is carried out with the finest silk obtainable threaded on swaged needles. The suture catches only the perineurium and never enters the substance of the nerve.

When repair of the deeper structures is complete the fascia is accurately united with fine silk sutures and the skin wound is accurately closed. No drains are left in the sutured wound.

It has been suggested above that when loss of covering tissue has taken place repair of injured deeper structures should be postponed. Time and function, however, can be saved, and long continued infection and formation of crippling scar tissue avoided if such wounds are closed at the

CASE HISTORY

primary operation. A graft of intermediate thickness, a full thickness graft or some type of flap may provide the best solution in any specific case, but, if it is in any way possible the wound should be closed, and without excessive tension. If relaxing incisions are made to permit skin edges to come together without tension the raw surfaces left at the site of the incisions should be immediately covered with razor grafts and not left to heal by granulation and scar formation.

Finally the injured part should be im-

mobilized in such a position as to relieve tension on injured tissues and put them at rest. Just as fractured bones, fractured tendons, nerves and soft tissues require reduction and immobilization in such a position that no undue strain is put upon any of the fragments (Fig. 8). Unless this is done, and particularly with fractured tendons, either the suture will give way completely, or it will cut through the ends of the tense tissue; in either case separation takes place and no helpful result is accomplished.

CASE HISTORY

It is suggested that the reader peruse this case history carefully; come to his own conclusions, and then turn to page 56 for a discussion of the same.

History.—G. P., a married white woman, aged twenty-nine, entered University Hospital on August 30, 1938, complaining of pain when she moved her eyes, and swelling of the eyelids. On two occasions early in August, 1938, she had sampled liberally of uncooked meat loaf containing pork. On August 26, she noted burning of the eyes and a headache. Two days later it was difficult for her to move her eyes because of pain and the following day (August 29) her eyelids became "swollen shut." Chronic constipation was present at the time of admission.

The systemic, past and family histories were not contributory to her present illness.

Physical Examination.—Physical examination at the time of admission revealed a well developed and well nourished white woman who appeared moderately ill. Her temperature was 101.8, pulse 120, and respirations 30 per minute. There was moderate edema of the eyelids bilaterally; most marked above, this was also present in the conjunctivæ. The ophthalmoscopic examination showed no abnormalities. There were hypertrophic septic tonsils. The chest and heart examinations were not abnormal. There were no palpable abdominal visceral enlargements. Muscular tenderness was not demonstrable. Neurological examination was normal.

Laboratory Data.—The blood Kahn reaction was negative. The urine showed no abnormalities. The

admission blood studies showed a hemoglobin 88 per cent (Sahli); R.B.C. 4,410,000; W.B.C. 10,900 and a differential of 75 per cent neutrophils, 5 per cent eosinophils, 18 per cent lymphocytes, and 2 per cent monocytes. Subsequent blood studies showed a rise of the eosinophils to 37 per cent with a 21 per cent value at the time of discharge, the total W.B.C. being 8,500 at that time. No parasites were found in the stools. The blood sedimentation rate was slightly elevated on admission but fell to normal before discharge. The skin test with trichina antigen (1-10,000) showed a positive reaction within five minutes. The blood precipitin reaction for trichinosis was positive up to and including dilutions of 1:800. E.K.G. examinations were not abnormal.

Clinical Course.—On September 9, there was soreness of the muscles of her neck, upper and lower extremities, at which time the edema of the eyes had disappeared. Her temperature ranged between 101 and 102.8, falling by lysis and reaching normal by the 13th hospital day. Before discharge a tonsillectomy was performed. The microscopic examination of the pharyngeal muscle tissue obtained showed small foci of interstitial myositis with areas of eosinophilic infiltration as well as encysted trichinæ. At the time of discharge she was entirely asymptomatic.

HISTORICAL ASPECTS OF IRON THERAPY IN ANEMIA: CHAIRMAN'S ADDRESS

While iron has been prescribed for almost three centuries, its therapeutic use is far older than the rational explanation of its action, and opinion concerning its value has changed greatly from time to time. Russell L. Haden, Cleveland (*Journal A.M.A.*, Sept. 17, 1938), reviews the most pertinent clinical literature on the subject. The most recent development in iron therapy has been the renewed emphasis on the greater potency of ferrous salts. While any iron preparation is effective if given in large enough doses, very much less of the ferrous compounds needs to be taken. Thus the two fundamental principles of iron therapy, large doses and the use of a ferrous salt, now generally accepted, only confirm what Bland, Niemeyer, Immerman, Osler and others thought and practiced. These principles, forgotten by clinicians for many years, have only recently been learned anew. Such rediscoveries emphasize again our debt to the great clinicians of the past.

TREATMENT OF SOME COMMON DISEASES OF THE SKIN*

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NEW YORK CITY



HOWARD FOX

The following remarks on the treatment of diseases of the skin may not accord fully with the views of some of my colleagues, as they are based almost entirely on personal experience. My discussion will include the treatment of some inflammatory diseases, infectious granulomas and pyogenic infections.

Acne vulgaris responds well to treatment as far as disappearance of the lesions is concerned. I know of no satisfactory method, however, of treating pitted scars that occur in the severe cases. In at least 85 per cent of the cases, a permanent cure can be obtained by fractional doses of roentgen rays, given at weekly intervals for three to four months. It is always advisable to warn the patient that, after such therapy, scars may be present and that these are due to the disease itself and not to the treatment. Ultraviolet therapy is of some value in persons who tan easily, but its effect is more or less temporary. Soap frictions and sulphur lotions, combined with mechanical methods, are time-honored procedures which suffice for the treatment of mild cases. Vaccine therapy, in my opinion, is worthless, though such treatment is still widely employed by the general practitioner. Diet is also of little value. Hormonal therapy is theoretically indicated but up to the present its results have been unsatisfactory. It is still in the experimental stage.

Rosacea is a common disease, especially in women, and requires internal treatment primarily. It occurs mainly in persons of middle age who lead a sedentary life and particularly those who suffer from indigestion. A trial of dilute hydrochloric acid is always indicated and is followed, at times, in several weeks by astonishing improvement or recovery. The general treatment can be summarized by getting the patient into the best possible physical condition, into "training" in other words.

The severe type of rosacea (rhinophyma), consisting of large hyperplastic nodular swellings of the nose, occurs entirely in men. It is not necessarily due to the excessive use of alcohol, though this is often

an important cause. The milder types of rhinophyma can be improved by scarification, though few patients are willing to submit to this treatment. It produces results, however, without appreciable scarring. The large noses with lobulated masses, can be destroyed by electrodesiccation under local anesthesia, or can be surgically excised under general anesthesia. The nose is practically whittled down like a stick to the normal size and healing takes place in about five weeks without the intervention of skin grafting.

For the treatment of poison ivy dermatitis, nearly every physician has his pet remedy, the chief value of which is to lessen itching and edema. These remedies do not materially shorten the course of this self-limited disease. Immediately after exposure to one of the poisonous rhus plants, soap containing free alkali, such as laundry soap, is indicated for the hands or other parts which have come in contact with the plant. Later, cold, wet dressings of boric acid are useful to reduce swelling, after which the ordinary calamin lotion (using pure lime water and no phenol) can be applied. While the disease cannot be aborted as a rule, prophylactic treatment has, I think, been proven to be of value. This can be given as intramuscular injections of poison ivy extract for several doses at intervals of a few days or the tincture of rhus toxicodendron may be given by mouth, beginning with a few drops and increasing daily till a dram is reached. The patient

*Read before the Seventy-third Annual Meeting of the Michigan State Medical Society, Detroit, September 22, 1938.

may then continue to take a teaspoonful of the drug once daily during the poison ivy season.

The treatment of bromoderma is a simple matter as soon as the correct diagnosis is made. If the characteristic acneform pustules or granulomatous masses are suspected of being due to bromides, the suspicion may often be confirmed by a history of having taken the drug. Many patients do not consider soda fountain remedies to be drugs and it is always wise to ask directly whether bromo-seltzer has been taken. I have photographs of two severe cases of bromoderma due to long-continued use of this nostrum. In one case the eruption had been present for four years without recognition of its true nature. Withdrawal of the drug is followed by disappearance of the eruption, though this is often slow. To expedite a cure, the patient may be given physiologic salt solution intravenously in doses of 100 c.c. at intervals of a few days, three or four times. This procedure also makes it easier to demonstrate bromine in the urine.

A single attack of herpes simplex, whether on the lips or genitals, is of little consequence. When, however, the disease recurs every few months for years, it becomes a problem of some importance. I have recently seen a woman who had had recurring attacks of herpes of the neck four times a year for twenty years. Each attack was accompanied by three or four different groups of vesicles. A simple method of treating such cases consists of inoculations of smallpox vaccine once a month for four consecutive months. In a reasonable number of cases this method is successful, favorable results occurring whether or not the vaccine "takes." In a report to be published later, Dr. Richard Kelly states that he has been able to abort attacks of herpes by intradermal injections of Moccasin snake venom. He also found that the attacks were less frequent after this treatment. In a few cases of recurrent herpes, I have seen a complete cessation of attacks after several roentgen-ray exposures confined to the affected areas of the skin.

Herpes zoster is a self-limited disease which rarely recurs. I know of no means by which its course can be shortened. All we can do is to lessen pain, attempt to prevent scarring and pay close attention to the cases which affect the eye (herpes ophthal-

micus). Zoster apparently causes no pain in children under ten years of age. Pain is often severe in elderly people and may persist even for years after disappearance of the eruption. I have seen some favorable results in controlling pain by the use of pituitrin, though my experience with intravenous use of iodides as recommended by Ruggles has not been satisfactory. Years ago I found that pain could be controlled by paraffin sprayed on the affected skin by a special atomizer or simply dabbed on the parts, which were then covered by a voluminous layer of absorbent cotton held in place by a bandage. In the cases which I reported, the pain was usually relieved at the end of 24 to 48 hours. Caution was necessary, however, in removing the cotton to avoid rupture of the vesicles. Zoster ophthalmicus is always alarming, though it is rarely followed by permanent injury to the eye. Every case of this type should be seen by a competent ophthalmologist.

In treating psoriasis, one may often obtain temporary results, though it is always difficult, in extensive cases, to remove every vestige of the eruption. The treatment can be summed up by the words "soap and water, grease and sunshine." Curiously enough, some physicians do not realize that soap and water are nearly always indicated in psoriasis, especially for removal of scales. The best remedy is natural sunshine for persons who are able to acquire a tan. As long as the skin remains tanned, such persons will be largely free from psoriasis. Unfortunately, ultraviolet rays from artificial sources are not as efficacious as the sun's rays. A fairly satisfactory method, however, of using ultraviolet rays from quartz lamps, consists of an application of crude coal tar at night, which is then removed, followed the next day by irradiation (Goeckerman method). Among the various reducing drugs, chrysarobin has held a high place for many years and is best used in ointment form. Whenever an intensive action is desired, the ointment should be applied to the skin and covered by an impermeable substance, such as oiled silk. This is specially indicated for thickened patches on the legs, where even prolonged exposure to the sun's rays may not cause the patches to disappear. The use of chloroform or traumaticin as vehicles for chrysarobin is much less efficacious than ointments (of

vaseline or lanolin). For the past few years, I have used the proprietary remedy, anthralin, rather extensively and prefer it to chrysarobin. It has been found by Cornbleet to be a stronger reducing agent and is somewhat less disagreeable than chrysarobin.

Lupus erythematosus is still an obstinate disease to treat, though the introduction of gold salts has somewhat simplified the problem. The favorite preparation in this country is gold sodium thiosulphate, the initial dose of which should be 5 to 10 mg. The maximum dose should never exceed 50 mg. in my opinion, if disagreeable reactions are to be avoided. The drug is given intravenously at weekly intervals for weeks or months, if necessary. Small areas, which are refractory to intravenous therapy may be treated intradermally, as suggested by Traub and Monash, the results being surprisingly good at times. Intramuscular injections of bismuth may be used in place of gold salts, but in my experience their action is slower and somewhat less satisfactory. My results with quinine bisulphate, in a small number of cases, have been disappointing. The aforementioned methods apply only to the fixed type of the disease. The treatment of the disseminate type of lupus erythematosus is unsatisfactory.

The treatment of pemphigus vulgaris in adults is extremely discouraging as the disease is nearly always fatal within three to eighteen months after onset. New remedies have been enthusiastically suggested from time to time but have thus far been dismal failures. The Davis method of giving arsenic and an extract of blood platelets on alternating days and treatment by large doses of viosterol have largely been discarded. The profession is now experimenting with germanin, a drug that is dangerous, especially from its action on the kidneys. I have not been favorably impressed with its use in pemphigus. The best local treatment consists of greasy applications, such as boric acid ointment. The dry method of using dusting powders usually fails. Until we know more about the disease, which is possibly due to a filterable virus, pemphigus will continue to be largely a problem of nursing.

Sycosis vulgaris, of staphylococcic type, has long been the *bête noir* of dermatologists. Even epilation by roentgen rays fails to cure some of the cases. The recent intro-

duction of the proprietary remedy, compound quinolor ointment (Squibb) has enabled us to cure many cases of this obstinate disease. It is often necessary to continue the use of this ointment for months after the disappearance of the eruption, due to its tendency to relapse. This remedy is also of value in cases of staphylococcic folliculitis that occur on the limbs, especially in hairy persons. If sycosis vulgaris (bearded region) is to be treated by roentgen rays, this agent should be applied in epilating doses. The practice of giving a series of a dozen or fifteen fractional doses at weekly intervals is usually followed by failure.

Of the various types of tuberculosis of the skin, lupus vulgaris, as its name implies, is the commonest. It is a serious disease, due to its chronicity, its tendency to disfiguration and its possibility of dissemination, and death. Lupus is poorly treated in this country, due to the lack of special hospitals similar to the Finsen Institute abroad. The mercury vapor quartz lamps are, unfortunately, poor substitutes for the large Finsen lamps. When the disease is seen early and consists of one or two small patches, the proper treatment, in my opinion, is excision. Great improvement, though not a cure, may be obtained by a salt-free, high-vitamin diet. The roentgen rays are useful in hypertrophic and ulcerating types of lupus vulgaris and also for scrofuloderma and the verrucous type of cutaneous tuberculosis. The best treatment for papulonecrotic tuberculide is the administration of antisyphilitic remedies, including arsphenamin or allied drugs and bismuth. This is highly recommended by Darier, with whose opinion I heartily concur.

The treatment of a furuncle should include advice to the patient not to squeeze or otherwise traumatize the lesion. One of my patients, suffering from two large boils of the face, disregarded this advice and, as a result, suffered from a metastatic abscess of the prostate gland, which occasioned an illness of two months' duration. Attempts to abort furuncles have rarely been successful in my experience. For the treatment of a succession of boils (furunculosis) I always advise a trial of vaccine therapy. In my experience, this has usually been successful when properly carried out. The proper procedure is to use a tuberculin

syringe and give one minim as the initial dose, gradually increasing doses to be given every five days, for eight to ten injections. If new boils appear during the course of treatment, the dosage should be lowered. Furthermore, I think stock vaccines are usually as efficacious as autogenous ones. I am now convinced that dietetic treatment has little or no value, except in frank cases of diabetes. It is rare to find any change in the sugar content of the blood in the vast majority of cases of furunculosis. In fact, satisfactory results were obtained by Tauber in a large series of patients who were purposely given a high carbohydrate diet.

Impetigo contagiosa is most often treated in this country by ammoniated mercury ointment in 5 to 10 per cent strength, although some persons are sensitive to this drug. Under any circumstances, this should not be used immediately before or after iodine has been applied as the resulting mercuric iodide is extremely irritating to the skin. Painting the areas (after removal of crusts) with silver nitrate is effective but temporarily disfiguring. The same is true of various dyes such as gentian violet and brilliant green (1 per cent aqueous solution). Alibour water is highly recommended by Darier and consists of copper sulphate grm. 2, zinc sulphate grm. 7 in camphor water, grm. 300. A tablespoon of this stock solution is added to a glass of water for external application every hour. This remedy is effective though its application is somewhat time-consuming.

Sulfanilamide has proven to be an invaluable remedy for erysipelas and has entirely supplanted the use of anti-streptococcal serum for the treatment of erysipelas in Bellevue Hospital. A voluminous literature has already appeared on the use of this new contribution to chemotherapy. Striking results were recently reported by Chargin from the use of sulphanilamide in chancroid. In my recent service in Bellevue Hospital, I also observed some astonishingly good results, particularly in chronic phagedenic types of this disease.

The treatment of common warts would supposedly be an easy matter. This is by no means true if the lesions are to be removed with little or no scarring or pain. Roentgen rays are successful in only a minority of cases, but are worthy of trial when the lesions involve the nail folds. I am opposed to treating common warts by electrodesiccation, which is apt to leave scars. The best method, I think, is to freeze the lesion with ethyl chloride spray and then remove it by a sharp bone curette. The wart is removed en masse with little or no scarring. The curette is also useful in removing juvenile flat warts, which also occur not infrequently on the bearded region of men. The idea that verrucae might be caused to disappear by mental suggestion has been scientifically proven in a large series of cases by Bloch. It seems incredible that an organic lesion, known to be due to a filterable virus, could be influenced solely by the mind. I have sometimes been annoyed after favorable results by the roentgen ray treatment to think that they may have been merely due to suggestion in an impressionable person, such as a child. Juvenile flat warts often disappear in a few weeks after oral administration of protiodide of mercury, $\frac{1}{4}$ grain tablets two or three times a day. My successes with this method have been mostly confined to young patients.

As alopecia areata is a rather capricious and self-limited disease, it is difficult to evaluate remedies used for its treatment. I feel convinced, however, that intensive local stimulation is worth a trial, except in cases of complete loss of hair. Small patches may be painted every two weeks with pure phenol until they are white. For the more extensive areas, the mercury vapor quartz lamps offer a convenient and cleanly method of stimulation. Irradiation should always be given to the point of an erythema, followed by desquamation. I am thoroughly convinced, and my dermatologic colleagues will agree with me, that antuitrin is of no value in the treatment of alopecia areata or, in fact, any other type of baldness.

POLIOMYELITIS IN KENT COUNTY: STATISTICAL SUMMARY

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GRAND RAPIDS, MICHIGAN

The outbreak of anterior poliomyelitis in Kent County during the late summer of 1935 was more extensive than in previous years. During the latter part of August and the early days of September, we were able to study thirty-eight cases. These cases were hospitalized and carefully watched over a period of two and one-half years.

On entrance the patients were placed in isolation. Complete blood and spinal fluid studies were made. Following the period of isolation and cessation of the acute stage, muscle tests were made and the group was periodically reexamined. The following outline summarizes the study:

Morbidity.—All cases occurred within a three-week period, the peak arriving on the sixth day. Following this day there was a slow but gradual decrease. The period extended from August 12 to September 2 (Fig. 1).

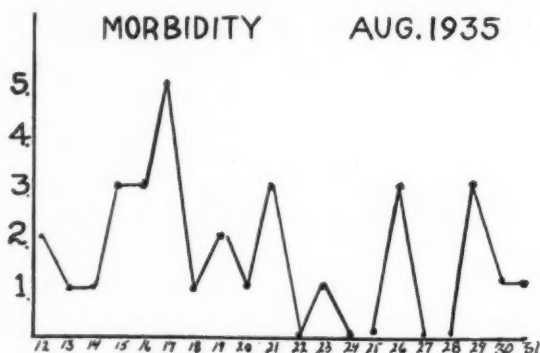


Fig. 1

Distribution.—Cases occurred equally in urban and rural areas. In two instances two members of a family presented symptoms.



Fig. 2

Age Incidence.—Most cases occurred between the ages of five and ten years. The oldest case reported was thirty-five years; the youngest, two years (Fig. 2).

Complaint.—The complaints of the patient were carefully recorded, and in the young children the parents were thoroughly questioned as to the type of onset. The following complaints are recorded in the order of frequency:

Headache	26
Generalized aching	20
Nausea	16
Stiff neck	14
Sore throat	13
Restlessness	13
Constipation	6
Difficult breathing—Diaphoresis	3
Vomiting	2
Diarrhea	2
Photophobia	1

From this list one can readily see that headache and general malaise were almost a constant complaint.

Clinical Examination.—

Injected throat	25
Rigidity of neck	24
Rigid spine	20
Positive Kernig	12
Hyperactive knee jerks	12
Loss of abdominal reflex	8
Loss or weakness of knee jerks	8
Loss of muscle power	6
Lethargy	5
Muscle tenderness	3
Diaphoresis	3
Abdominal breathing (no intercostal excursion)	2
Photophobia	1

The highest temperature recorded on admission was 103 degrees, the lowest, 98 degrees. The average range of temperature was five degrees. At no time was there a temperature above 103 degrees. The highest pulse rate was 140, which was recorded in a case of intercostal paralysis. This case also carried a respiratory rate of 40 per minute.

Laboratory Findings.—The white blood counts varied considerably. The lowest was 3,299 with a normal differential. The high-

est recorded was 17,200 with the polymorphonuclear cells at 80 per cent and the lymphocytes at 17 per cent. The average white blood cell count was 9,365. The spinal fluid counts were as variable as the blood pictures. The lowest cell count was eight cells, and the highest 1,060 cells. The greater number of cases ran counts between 50 and 100 cells (Fig. 3).

SPINAL FLUID COUNT

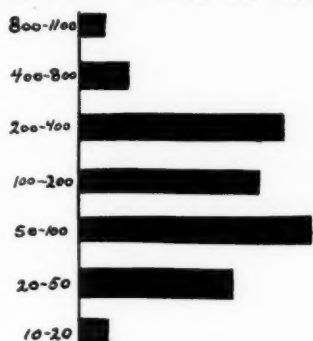


Fig. 3

Globulin was positive in twenty-three cases. The sugar content did not show any marked reaction. The lowest reading was 42 milligrams; the highest, 71.5 milligrams. In twenty-three cases the lymphocytes predominated over the polymorphonuclear cells in a ratio of two to eight. The remainder of the cases revealed the neutrophils predominating over the lymphocytes in a ratio of 5.5 to 4.5.

were immediately isolated and subjected to a spinal puncture and blood study. Sandbags and plaster of Paris splints were used where necessary. The patients received 50 to 400 c.c. of convalescent serum in divided doses. A few patients having paralysis on admission were not given serum. All patients were kept flat until the isolation period was up. They were then given muscle

SEVERITY OF WEAKNESS

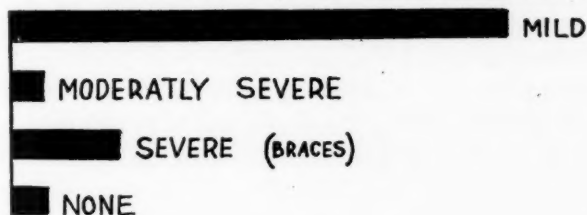


Fig. 4

tests depending upon their general condition. Those cases in which there was pain were not examined until cessation of muscle tenderness.

Distribution of Weakness.—It is extremely difficult to record in chart form the distribution of weakness. The lower extremities, back, and abdominal musculature predominated. Two cases of intercostal paralysis also presented weakness in the lower extremities.

Severity of Weakness.—After the cessation of the acute stage, the cases were arbitrarily classified as normal, mild, moderate-

PRESENT STATUS

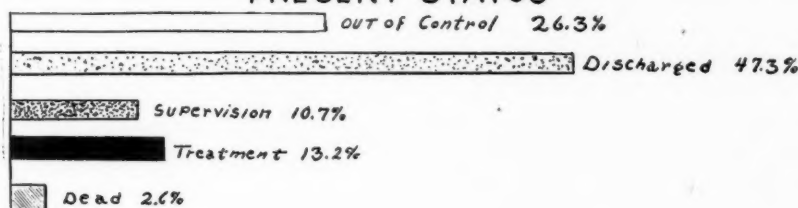


Fig. 5

In endeavoring to correlate the spinal fluid count with the white blood cell count, no constant data could be recorded. In the majority of cases both the white blood cell count and the spinal fluid count were increased, but in no definite ratio. In one case the white cells of the blood numbered 12,450 per cubic millimeter and the spinal fluid cells numbered 296; in another, the blood cells were relatively normal and the spinal fluid counted 275 cells.

Treatment.—On admission all patients

ly severe, and severe. The moderately severe cases have shown improvement and are periodically examined. The severe cases are still under active physiotherapy and continue to wear braces (Fig. 4).

Present Status.—Ten patients failed to return for reexamination. Eighteen patients were discharged from further care after a year of periodic examinations. Four patients are being reexamined every few months, particularly to watch for limp and scoliosis. This latter condition develops in-

sidiously in children with a back involvement even though it be mild. Five patients, two of whom are adults, continue to wear braces and are under active physiotherapy treatment. One patient of the bulbar type died in the acute stage of the disease (Fig. 5).

Comment

Nothing unusual or new is evolved from studying this small group of cases. However, the list of complaints and findings bring to mind the multiplicity of signs and symptoms presented in this disease. In a number of cases the diagnosis was questionable. We treated all cases as acute anterior poliomyelitis until proven otherwise. No case was finally diagnosed as encephalitis.

It is of interest to note the fallacy of the

term "Infantile Paralysis." Only in a very small per cent of the cases was paralysis present, and of these two adults were included.

One patient complained of a worm-like, hot, boring sensation under the skin, for a period of two weeks. This implied to us inflammation of the posterior horns of the spinal cord and a poor prognosis for the return of muscle function. This individual still has one flail arm and hand and a very weak shoulder girdle on the opposite side.

Rest in bed is essential. Patients were kept flat from four months to a year, depending upon the severity of the involvement. During the acute and early convalescent stages, the position of physiological rest was maintained by sandbags and plaster splints.

THE BONE MARROW FROM A CLINICAL DIAGNOSTIC VIEWPOINT*

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It is common knowledge that the concept of diseases of the blood has changed. As a purely descriptive title this term has served for many years to include a group of diseases characterized by changes in the cellular elements of the circulating blood. But with the impetus given by the discovery of the anti-anemic principle in liver and the investigation of its action, attention has been directed more and more from the peripheral blood toward the hematopoietic tissues, and particularly to the bone marrow. The so-called diseases of the blood are now fairly well understood to be really diseases of the blood-forming organs.

More detailed knowledge of the anatomy and physiology of these organs would throw additional light on the pathology of the disorders affecting them, and would aid materially in diagnosis. But it is only within very recent years that such knowledge of the marrow has been obtained, and it is still imperfect. Less than ten years ago, authoritative writers referred to the lack of definite knowledge of the normal anatomy and physiology of the bone marrow, but as the result of their researches,^{6,7} and others, a fairly comprehensive understanding has been attained. The prompt application of this knowledge to the study of disease states indicates how much it was needed; and the result has been that we now regard many

hematological disorders more rationally, and treat them more intelligently.

The bone marrow may profitably be regarded as a definite organ,² although it is spread throughout the skeleton. In infancy red, cellular marrow fills the medullary cavities of all the bones, but in a few years fat begins to appear. At about the age of twelve to fourteen years a patch of fat develops in the middle of the shaft of the long bones, and this gradually enlarges until in the adult there remains only one small area of red marrow near the upper end of the diaphysis. Red marrow continues to occupy the ribs, vertebræ, sternum, skull and the innominate bone throughout life, and the fatty marrow of the long bones may be quickly reconverted into functioning, cellular tissue in response to increased demand or by disease.

*Read before the Seventy-second Annual Meeting of the Michigan State Medical Society at Grand Rapids, September, 1937.

The size of the marrow is not generally appreciated. There is, roughly, half as much total marrow as there is circulating blood, and of this about half is red and half yellow or fatty. The red marrow alone is approximately equal in weight to the liver, and the reserve of fatty marrow makes possible an actual doubling in size. The capacity of the normal marrow to produce cells is enormous; it is estimated that in a healthy adult the output of red cells is about 900 billions daily.³

Microscopically, the great variety of marrow cells and their seeming lack of organization might cause one to wonder how any orderly cycle of development could be discovered. The marrow, unlike most other organs, is not composed of fully differentiated cells already adapted for their function, but contains primitive, undifferentiated forms which are constantly maturing and passing out into the blood stream. Although a detailed account of their development is out of place here, some consideration of this process is necessary for an understanding of the changes which are recognized in disease. Investigators have simplified the problem somewhat by selecting for study, situations in which new islands of hemogenesis appear in the fat, so that the number of cells is relatively few. Thus Sabin studied the developing chick embryo, and Peabody the erythropoiesis following infection.

The basic structure and growth of the marrow is simple, in spite of the appearance of the ordinary microscopic section. There are only two varieties of cells to begin with—endothelial cells, which form the capillaries, and reticulum cells, which form a fine inter-capillary network and sinusoidal spaces. All of the developing blood cells arise from one or the other of these. The so-called fat cells of the marrow are not cells at all in the physiologic sense, but merely reticular spaces filled with coalesced fat droplets. In the erythrocyte series, the youngest cell which can be differentiated is the erythrogonia, which is too immature to show hemoglobin. In succeeding generations it presents the features of the erythroblast, megaloblast, normoblast, reticulocyte and finally the mature erythrocyte. Release of erythrocytes into the circulation occurs normally at about the end of the reticulocyte stage, as is evidenced by the presence

of about 1 per cent of these cells in the circulating blood. In health the bulk of erythropoietic tissue is made up of cells at the normoblast level with relatively few of the younger forms. But the latter have almost unlimited capacity for proliferation under abnormal conditions.

In the granulocyte series, the youngest cell which can be differentiated is the myeloblast. By nuclear and cytoplasmic changes it becomes successively a premyelocyte, myelocyte, metamyelocyte, non-segmented polymorphonuclear and, finally, a mature segmented polymorphonuclear. Delivery of granulocytes into the circulation occurs normally just before and during the final lobulation process in the nucleus, so that the peripheral blood shows cells with varying nuclear forms, but only a small number of the younger non-lobulated class. The majority of the developing granulocytes in the marrow are in the myelocyte and metamyelocyte stages, with relatively few of the very young forms. But again, these young cells have tremendous capacity for proliferation under abnormal conditions.

In addition to erythrocytes and granulocytes the marrow contains small numbers of the other blood cells—lymphocytes and monocytes; also megakaryocytes—the parent cell of the blood platelets—and a few plasma cells. Any of these may proliferate to abnormal proportions in disease. Whether or not lymphocytes and monocytes are normally produced in the marrow in any significant numbers is a debated question, and unimportant for the purposes of this discussion; pathologically they are so produced.

Ordinarily, the peripheral blood reflects fairly accurately the state of the marrow. Increased cells in the circulation denote greater marrow activity, and decreased cells the opposite. Usually some change in the average cell maturity accompanies altered numbers. Thus, the ordinary leukocytosis is characterized by more young polymorphonuclears or non-segmented forms. But there is a definite threshold for cell delivery which prevents cells normally confined to the marrow from overflowing into the circulation. This is a distinctly separate mechanism from the process of cell formation and definitely separates the circulating blood cells from their tissue of origin. Very little is known of the factors which main-

tain the normal levels of the circulating cells beyond the fact that they are concerned with many of the general physiological processes of the body, and particularly with certain of the glands of internal secretion. Cell delivery may be materially changed, as, for example, in pernicious anemia and in the leukemias, where very immature cells reach the blood stream. Clinically this is important because the question as to how closely the peripheral blood reflects the state of the marrow depends very largely upon whether this "release factor" is effective or not.

Comparative data concerning the blood and the marrow indicate that in most of the major hematological disorders there is a definite correlation between the two. That is, a characteristic marrow picture exists as a counterpart of the blood picture. From experience, the state of the marrow in a given case may be inferred from the changes in the peripheral blood, but such inference will be accurate only insofar as the delivery of cells from the marrow occurs as assumed. It is obvious that when cells are retained in the marrow, no proof or even suspicion of their existence can be obtained from the blood. Although this situation is not common, it occurs often enough both with normal and abnormal cell forms to cause important diagnostic difficulties. It is the experience of everyone who sees many of the so-called blood dyscrasias that some patients show little or nothing in the ordinary blood study upon which to base a diagnosis, yet the symptoms and signs of serious disease are definite. It is no longer good medical practice to label such a case as "severe anemia" or "splenomegaly" or whatnot without trying to gain additional information from the bone marrow.

It is well to bear in mind that the ordinary blood study (cell counts, et cetera) is actually a biopsy, although a very simple one. The object is to study cellular structure and relations just the same as in any other tissue removed from the body. To carry out a similar procedure on the parent tissue of the blood is a logical step toward detecting disease at its probable source. For clinical purposes the actual technic is simple,⁸ requiring no more skill or equipment than that needed for lumbar puncture, which operation it very much resembles.

Since the sternum contains functioning,

red marrow throughout life, and is moreover easily accessible, it is the most suitable place for obtaining marrow. A short, heavy, spinal puncture needle is a satisfactory instrument, although specially designed needles may be found more convenient. The anterior cortical layer of bone is easily penetrated after local anesthesia, being only about 1 to 2 mm. thick. The marrow cavity is about 1 to 1½ cm. deep and if entered at an angle, offers plenty of leeway to avoid penetrating the posterior cortex. The marrow is fluid and easily aspirated into a syringe; but a very small amount (only 1 or 2 c.c.) should be withdrawn so as to avoid dilution by inflowing blood. The marrow so obtained is immediately mixed with an anticoagulant and from it thin smears are made which can be stained and studied exactly like those from blood. In fact, any of the procedures used for blood can be carried out with the fluid marrow, including total cell counts; but the examination of the stained film yields the most useful and important information.

Marrow may also be obtained by removing a small core of tissue by means of a trephine, and this method preserves the structural relationship of the cells. But it is technically more complicated, requires more time and manipulation for the preparation of microscopic sections and is not well adapted for repetition on the same patient. It antedates the puncture method but is now seldom used for clinical diagnostic purposes.

The use of marrow biopsy in clinical medicine is in its infancy, but already there are very definite indications for it. It may be expected to become more and more widely used as detailed information of marrow changes in disease is accumulated. At present the diseases that present a specific marrow picture upon which a definite diagnosis can be based are comparatively few; but correlation with the clinical and peripheral blood findings may be expected to increase its usefulness steadily. Among 125 cases of various hematological disorders thoroughly studied by a recent investigator,¹ the diagnosis was not settled by the usual means in twenty-six. Of these twenty-six cases marrow study furnished a definite diagnosis in twenty, while the other six remained obscure. According to present knowledge there are three groups of dis-

eases in which this procedure yields diagnostic information.

In severe anemia of the aplastic type, borderline cases occur in which questionable signs of regeneration may show in the blood and the diagnosis therefore remains in some doubt. Even though a cause for the anemia can be identified, as, for example, benzol, arsphenamine or excessive radiation, the question of possible recovery cannot be answered without knowledge of the state of the marrow. Failure of erythropoiesis sometimes occurs late in the course of several of the major hematological disorders and requires recognition at least. In these cases extreme exhaustion of all cellular elements may be found in the marrow and definitely settles the diagnosis; and since such a marrow cannot be restored to any significant functional activity, the futility of such measures as transfusion is apparent. Some instances occur, however, in which the marrow does not show what the circulating blood has indicated and may be merely hypoplastic or even normal. The difficulty lies in the altered threshold of cellular release and is much less serious. It must be borne in mind that marrow puncture is a sampling process, and since the lesions may be patchy, there is the chance that the sample is not representative. It is therefore inadvisable to base the diagnosis of marrow aplasia on only one biopsy.

It may be mentioned in passing that in certain other anemic states marrow biopsy, while not of prime diagnostic importance, may furnish useful information. It is stated that true Addisonian anemia may be distinguished from carcinoma of the stomach with blood changes resembling pernicious anemia through study of the marrow. Of course, other and usually simpler means will accomplish the same purpose. Sub-acute combined degeneration of the spinal cord, of the type seen in pernicious anemia, may occur before any change in the blood is evident, and sternal puncture may offer an earlier means of making the diagnosis in this very puzzling situation. Malarial parasites are said to be more numerous in marrow erythrocytes than in those in the blood stream. Culture of marrow fluid for the purpose of studying cell growth is at present an almost unexplored field, but one which offers great promise.

The severe neutropenias with grave con-

stitutional symptoms, loosely called "agranulocytosis," make up the second group of diseases in which marrow biopsy is of diagnostic aid. In the fifteen years since this syndrome was described, many questionable cases have appeared in the literature, and much work concerning its possible causes has proved valueless because of lack of critical analysis of the clinical and pathological findings. Marrow studies have helped to clarify our knowledge of these neutropenic states. It has been demonstrated that the peripheral neutropenia may or may not reflect the actual state of granulopoiesis, and that neutrophil formation may be normal, increased or decreased. The essential difficulty may thus relate to cell formation in some instances and to cell delivery in others. In either event marrow biopsy is the only means for determining the fact. A certain number of cases of so-called agranulocytosis have proved to be instances of aleukemic leukemia or of aplastic anemia with equivocal blood findings; and while an accurate diagnosis in such cases has no effect on the outcome, it may avoid needless confusion and the encouraging of false hope for recovery. In other instances the finding of a normal marrow will enable the physician to proceed with confidence in a favorable result.

The third group of diseases, and the one in which marrow biopsy at present shows its greatest diagnostic usefulness, includes some of the leukemias and closely related disorders. Typical leukemic changes in the peripheral blood are easily recognized and require no further investigation. But a considerable number of cases—more than is generally appreciated—do not show a diagnostic blood picture; and this is particularly true in the acute forms of the disease. Reference is sometimes made to "atypical" leukemia in which the clinical or hematological findings do not correspond to the classical description, but this is misleading because all leukemias show typical anatomic lesions. It is not the disease but certain of its manifestations which may be atypical, and it is in this type of case particularly that marrow biopsy is of diagnostic aid, for the leukoblastic tissue practically always shows characteristic proliferation, regardless of the peripheral blood findings. In one large pathological service,³ out of a total of fifty-six cases of leukemia, nine or 16 per cent

were aleukemic and none of these nine was diagnosed clinically because the marrow was not examined during life. Acute or subacute aleukemic leukemia may simulate various diseases, notably aplastic anemia, thrombocytopenic purpura, pernicious anemia and sepsis, and treatment may be correspondingly misdirected. There are rare instances of leukemia in which the lesion is confined entirely to the marrow. The chronic aleukemic myeloid form has often been confused with Banti's disease and splenectomy has been done.

Lesions of the skin as a part of the leukemic process are fairly common, and when they occur in the course of known leukemia they offer no diagnostic difficulty. But in the absence of any other definite leukemic manifestations, as sometimes occurs, a very puzzling situation may arise. Dermatologists^{4,5} have written extensively about the diagnosis of leukemia cutis and lymphoblastomas in general, in which group the nodular skin infiltrations in leukemia are classed. Clinically there may be a very close resemblance between the skin lesions seen in the various types of leukemia, Hodgkin's disease, lymphosarcoma and mycosis fungoides. Moreover, certain other cutaneous conditions such as exfoliative dermatitis, lupus erythematosus and dermatitis herpetiformis seem to bear a definite although unknown relation to leukemia, and may be preceded or followed by it. Marrow biopsy is of considerable diagnostic aid in such situations when the peripheral blood findings are inconclusive.

Clinicians have long been familiar with the leukemoid type of blood change which may occur particularly in response to infec-

tion or malignancy. There may be merely an unusually high leukocytosis in which case the resemblance to leukemia is slight. Or there may be many immature or abnormal cells in the blood which along with enlargement of the spleen or lymph glands, strongly suggest true leukemia. This differentiation has been extremely difficult at times, and often has had to rest on subsequent developments. Marrow biopsy should aid greatly in making the proper diagnosis.

Finally, it may be mentioned that tumors of the marrow, both primary and metastatic, are occasionally found by biopsy. Since these lesions are always patchy, it is largely a matter of luck, however, if they are picked up in the aspirated material.

Any medical inquiry into an illness begins, and ends, at the bedside. The clinician who anticipates a definite diagnosis in every case in which a biopsy is performed is doomed to disappointment, especially if the technical or laboratory details are handled by someone else. The hematologist himself is primarily a clinician, who studies the blood and its tissues of origin and brings to the bedside all the available data.

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INTERPRETATION OF EXCESSIVE GONADOTROPIC HORMONES EXCRETED IN URINE IN EARLY PREGNANCY

A. J. Kobak, Chicago (*Journal A.M.A.*, April 9, 1938), cites a case that demonstrates the difficulty in diagnosis when, after the expulsion of a hydatid mole, an unexpected pregnancy intervenes. The diagnosis was obscured by the contraceptive precaution. Furthermore, the possibility of a pregnancy occurring within four weeks from the date of the curettage was unlikely. With the uterus growing rapidly for one week, the hemorrhage and the hormone observations, the diagnosis of uterine pregnancy became even more dubious. The patient was admitted to the Michael Reese Hospital, where the uterus was emptied by an abdominal hysterotomy. It contained a normal fetus and placenta about 10 weeks of age. The left ovary contained a normal corpus luteum of pregnancy. The fibroids were removed and the patient made an uneventful recovery. Microscopic examination of the placenta showed nothing abnormal. Two subsequent Friedman tests were negative. When more negative reports are made, the diagnostic value of large quantities of gonadotropic hormones in the urine will be more limited. The clinical history and physical appearances should be given primary consideration before one concludes that chorionepithelioma or hydatidiform mole is present.

SOME REMARKS ON THE EXPERIMENTAL PSYCHOLOGY OF THE KRAEPELIN SCHOOL*

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Kraepelin was a pupil of Wundt. Wundt stated that empirical natural science resents philosophical speculations which are not based on experience.

He claimed that psychology should be based on philosophical premises but philosophical speculation shall only be recognized if it keeps in mind, at each step, the facts of psychologic experience as well as of experience of natural science. Plato liberated the soul from the body and opened the door to dualism. Aristotle softened the idea by carrying the soul as lifegiving and formative principle into matter. For him also the plant was a being with a soul. Descartes considered the soul exclusively a thinking being. Leibniz with his monad doctrine tried to replace the Cartesian soul substance by a more general principle, approaching again the conception of the Aristotolian soul. Herbart, so says Wundt, successfully refuted Wolff's theory of the power of the soul with its superficial classification of processes of the soul composed of memory, imagination, sensation, intellect, etc. Herbart, however, wasted the best part of his perspicacity by inventing an entirely imaginary system of mechanics of perception to which his metaphysical idea of the soul seduced him. Descartes became the most powerful influence of that method of thinking which led to modern materialism. If, so says Wundt, animals are natural automata, in which everything occurs purely mechanically, which is generally considered perception, feeling, will, why should this proposition not hold good for man? The materialism of the 17th and 18th century drew this conclusion. There are a great number of experiences, which leave no doubt that there exists a connection between physiologic processes of the brain and psychic activities. May these few remarks by Wundt in the first lecture on the soul of man and animal (1892) suffice for an introduction of the subject matter, namely, "Some remarks on the experimental psychology of the Kraepelin School."

Kraepelin who died October 7, 1926, in his seventies, worked in Wundt's laboratory. On pages 358 and following, of Wundt's *Physiologic Psychology*, 2nd volume, 1893, Kraepelin's work "The Influence of Some Drugs on Mental Efficiency, Jena

1892," is mentioned. It was a very important contribution. Incidentally, I mention that space and time does not permit to dwell on the most important work of Fechner, Weber, Ebbinghaus, Cattell, Galton and others. Kraepelin and his pupils have published their contributions from 1896 until 1928, when the last number of "Psychologische Arbeiten," Volume IX, part 3 and 4, appeared. In the introduction of his first volume Kraepelin says: "When in the winter of 1879 a modest room was given to Wilhelm Wundt for psychologic experiments, he could scarcely foresee the rapid advance of this new field of investigation. Fifteen years later pupils came from all over the world. Laboratories are now found in great numbers. Kraepelin entitled his introduction "The Psychologic Experiment in Psychiatry," but the investigations went far beyond it. The amount of work published is immense. August Hoch, M.D., has the following to say in his article "Kraepelin on Psychological Experimentation in Psychiatry" (*American Journal of Insanity*, January, 1896).

"He not only applied methods which were used in experimental psychology, but devised new ones particularly fitted for the investigation of abnormal conditions; and it is well to say at the beginning of the review that the objections which could be made to a study of this kind—namely, that experimental psychology is itself not enough advanced to be applied, so that it is questionable whether the methods there used are applicable to abnormal individuals—do not hold good, since Kraepelin takes the methods less from physiologic psychology, than the experimental method in general."

Weygandt (*Psychologische Arbeiten*), Volume IX, numbers 3 and 4, 1928, page 371, states:

"Yearly about 150 of our patients are examined psychologically. The forensically frequently very

*Read before the Detroit Philosophical Society, May 26, 1938.

important differential diagnosis between epilepsy and hysteria, between hypomaniac and other unrest, between paralytic epileptic and schizophrenic and other feeble-mindedness, between organic defects and compensation-hysterical disturbances, etc., find supporting evidence in this manner, and not infrequently a decision. The investigations are supplemented by alcohol reactions with psychologic investigations. If, in a case, only a vague suspicion existed concerning hypomaniac traits, the association experiment produced in more than 30 per cent reactions after the nature of word supplement, it entitles us to lean in court more strongly to the hypomaniac explanation and the deviation from logical orderly thinking."

The main factors which dominated some of the work of Kraepelin were the study of the influence of (a) practice, (b) fatigue, (c) the warming up effect, (d) the habit-forming which is lost very slowly in contrast to the warming up effect, (e) impulse, which is of short duration, also the influence of the will at the end of work, and the end-spurt. These efforts fight against the influence of fatigue (f) influence of disposition (good or bad disposition), (g) coöperation of influence of will and feeling, which is closely connected with the idea of coercion by imposed displeasing work in contradistinction to joy to work, (h) feeling of fatigue (psychopaths who break down by not noticing fatigue). We see that there are nine main factors at work.

Methods

Among the methods used by Kraepelin and his pupils, may be mentioned:

1. Physical measures of time with the aid of Hipp's chronoscope and the method of Cattell. The latter consists of visual impressions which appear before the eye with a certain measured velocity and are observed through a narrow slit. Objects may be letters, short or long words, sentences or illustrations.
2. Measurement of associations.
3. Fixation of association responses. The same associations appear after long intermissions.
4. The continuous methods of work first investigated by Oehrn, 1889, according to certain plans, (a) adding of single digits which consists in the reawakening of learned combinations of conceptions, (b) learning by heart of a series of twelve single digits or senseless syllables, as used first by Ebbinghaus. (Galton has examined that learning ability of mentally diseased children who could repeat only three to four

letters at a time, whereas mentally healthy children could repeat seven and eight.)

5. Reading. There is no method to measure the understanding but only the velocity with which a certain number of syllables are read (In this manner the nationality of a confidence man was established). Rieger has found many new facts in aphasic persons.

6. Writing gives mainly an insight in purely peripheral phenomena. Grashey and Goldscheider had induced Kraepelin to construct a "writing scale."

7. Measurements of the touch threshold (Griesbach). This is useful in following up fatigue.

8. Time estimation with fatigue. The measured time spaces become gradually shortened.

9. Examinations with the ergograph which allow to measure the work of certain muscles. Mosso had noticed that the work of the flexors of the hand was influenced by psychic influences.

10. Measurements of the depth of sleep in the various timespaces after going to sleep (according to Kohlschuetter).

Kraepelin admits that every endeavor to work out facts of experience by the mind can only be accomplished with the aid of imagination and therefore is apt to contain errors.

Let me refer to "The Principles of Scientific Management" of Frederick Winslow Taylor, Harper Brothers, 1911, and to the twelve principles of efficiency by Harrington Emerson, N. Y. (The Engineering Magazine Company, 1916).

If one considers the great amount of work which is done in this country in experimental psychology, we are surprised at the variety of questions which are answered in the various laboratories.

Kraepelin considered the "joy to work" as an essential point for national welfare. In our time, even in the United States, much consideration should be given to this factor. Kraepelin, in this manner, understood and emphasized the value of emotion many years ago.

He said in 1894:

"It is highest time that also with us, in psychologic questions, the serious conscientious individual investigation should replace ingenious statements and deep speculations. We do not get anywhere with

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things which we cannot prove or contradict. We need facts, not theories. It is true that no science can do entirely without comprehensive views and temporary hypotheses, but we must never forget that these have no intrinsic value and that they cannot be recognized per se. They are nothing but means to an end. They are only justified when they ask definite questions and, thus, lead to new investigations. I think, says Kraepelin, that a sufficiently large number of questions have been asked. We shall now begin to answer them, not sitting at the desk, but in the laboratory, not by ingenious thoughts but by measurements and observation."

William James (*The Thoughts and Character of William James* by Perry, 1938, p. 454) says:

"Every cognitive project is on trial, and bound to submit itself to fresh findings of fact, no matter what other credentials it may possess. This includes the judgment of science, common sense, religion, and metaphysics. A philosophy is called empiricism when same is contented to regard its most assured conclusions concerning matters of fact as hypotheses liable to modification in the course of future experience."

We must admit that the exact work of Kraepelin and his pupils has laid a foundation, the importance of which cannot be denied. Some may say that some of the results could have been imagined without experimentation. The very fact that the results gave an explanation coinciding with actual experiences, shows how reliable have been the methods employed by Kraepelin and his pupils. Guess work has been replaced by proven facts and exact measurements.

Let me mention a few practical deductions from the results of the investigations

of the Kraepelin School, some in connection with other investigators.

1. It is not right to place gymnastic exercises at the beginning of the school day, nor during the day. Gymnastic exercises belong at the end of the school day. Physical work tires the mind like mental work (Mosso, Bettmann).
2. Overwork of pupils can be prevented if the more difficult subjects are not placed at hours of the school day when the pupil is tired.
3. Intermission for rest must be longer at stated periods during the day.
4. Sufficient sleep is an absolute necessity.
5. The effects of exhaustive work can be traced for days and are not corrected by a one night's rest (Bettmann).
6. The strain of night work demands close attention.
7. School work and housework demand close control by mental hygiene. Attention must be paid to the various mental capacities of pupils.
8. The influence of alcohol and other drugs must be considered (Aschaffenburg and others).
9. The high pressure methods must be recognized in their damaging influences. (Incidentally, may I remark that nature cannot be deceived. We know that some people in their appearance, actions and health have used, or, better, abused, their physical inheritance so that their bodies are used up long before they should have been).
10. Like the thermometer is used to measure the body temperatures, the stethoscope to investigate the conditions of organs in the body, the medical laboratory to find changed conditions in bodily health, so do the investigations in psychophysical laboratories look into the rules which govern mental activities (Weygandt, etc.).
11. The work and evaluation of experimental psychology are only beginning to be recognized in their true value and in their importance for a healthy life of the individual and of the human race.
12. This work engages the efforts of trained observers and skilled interpreters, so that pitfalls may be avoided as much as possible.

THE BRAIN

(From Dr. Oliver Wendell Holmes' "Living Temple")

Then mark the cloven sphere that holds
All thought in its mysterious folds.
That feels sensation's faintest thrill,
And flashes forth the sovereign will;
Think of the stormy world that dwells
Locked in its dim and clustering cells.
The lightening gleams of power it sheds
Along its hollow, glassy threads.
O, Father, grant thy love divine
To make these mystic temples thine.
When wasting age and wearying strife
Have sapped the leaning walls of life,
When darkness gathers over all,
And the last tottering pillars fall,
Take the poor dust thy mercy warms,
And mould it into heavenly forms.

SUBMAXILLARY STONES

Case Report

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A brief review of the literature shows that in some regions more parotid stones than submaxillary are found. In other geographical regions the exact opposite is true. The composition of the stones is almost identical with tartar which collects on the teeth. Both swarm with micro-organisms. The etiology is as indefinite as is that of stones found elsewhere. The size of the stones varies from that of a millet seed to one over an inch in length. Each submaxillary gland, composed of around 1,500 lobules, is drained by Wharton's duct, the external orifice of which is found just behind the lower incisor teeth in the floor of the mouth. The ejection of saliva within the gland is accomplished by the secreted saliva within the gland which has been found to be greater than the arterial blood pressure when it is in full activity.

Submaxillary stones are found three times more often in males than in females. They may produce no symptoms and are discovered accidentally through x-ray examination. In most cases, pain is quite pronounced and occurs at the beginning of a meal. Another common finding is swelling, which occurs as soon as eating is begun. The swelling is located on either side, beneath the mandible, but if very great, may extend above. At times, a swelling is found in the floor of the mouth. Usually relief is sought because of secondary infection which has aggravated existing symptoms.

Examination often discloses saliva coming only from the unaffected side. At times the stone can be seen just behind the orifice of Wharton's duct as a yellowish object. If pressure is applied to the swelling, the duct balloons out. This same procedure may push the stone through the orifice. A great spurt of saliva follows.

The purpose of reporting this case is to call attention to the number of stones that have been recurring. The literature on submaxillary stones is very extensive but little is said about the same patient returning with more stones. Ivy and Curtis² had

one patient return after two years with a single stone on the same side, and another patient returned after two and one-half years with a single stone on the opposite side.

Case report of Mr. L. R., aged fifty-eight. Submaxillary stones have been removed from Wharton's duct exactly eight times since October 29, 1933. Stones were removed from the right side three times and from the left side five times. They were extracted from the duct by exerting pressure on the swelling and either dilating or incising the duct orifice. At times the stones could be seen through the orifice, at other times they were located further back. In all recurrences only one stone was found. All of the stones were very friable, crushing with slight pressure. The largest was only 0.5 cm. They varied considerably in shape, being cylindrical, round, ovoid, et cetera. The recurrence at times was very rapid. The first stone to be removed was on October 29, 1933, right side. Then, less than two months elapsed when the second one was taken from the left side on December 18, 1933. Nearly a year later, October 13, 1934, one was removed again from the left side. On April 23, 1935, a stone was removed from the right side. Twenty-two months later, on June 14, 1937, another stone was found on the right side. The last three have all been from the left side. They were removed on the following dates: December 28, 1937, January 5, 1938, and September 19, 1938. The only symptoms of which this patient complains is that of swelling. Each time it has occurred at the beginning of a meal.

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POSTERIOR VAGINAL ENTEROCELE*

Report of Two Cases

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The report and the discussion of the two cases presented here is to point out that exceedingly small series of cases of enterocele are still being reported and secondly to record a case that presents a complication not hitherto found in the literature.

Case 1 presents a posterior vaginal enterocele complicated by an acute intestinal obstruction and is as follows:

Case 1.—Mrs. —, a white woman, aged thirty years, was admitted to the hospital with symptoms of acute intestinal obstruction, May 31, 1936. She had been seized with a pain in the left pelvic region which was so severe that she fainted. When she returned to consciousness she had recurrent lower abdominal cramps and some nausea, and a feeling of pressure in the vagina.

Six weeks previously she began to have severe crampy pains in the lower left quadrant that came on suddenly. Since then at irregular intervals the pains returned and were often associated with heavy work. These pains would last for a few minutes to one-half hour and were accompanied by nausea, vomiting and a distinct sense of pressure in the pelvis. Decubitus relieved the attacks until the present illness.

Her past history was of no interest except that she had delivered two children and the first had been a long, hard labor.

Physical examination revealed the following pertinent findings. There was slight pain on deep pressure in the lower left quadrant. The genitalia revealed old lacerations of the perineal muscles. The cervix was pushed behind the symphysis by a fixed cystic mass in the posterior vaginal vault. The mass measured approximately 9 cm. in diameter and extended downward to the levator muscles. The mass could not be reduced by pressure through the vagina but when digital pressure was applied through the rectum the mass was reduced and the intestinal colic stopped; this maneuver had all of the characteristics attributed to the manual reduction of an incarcerated inguinal hernia.

Operation was performed, using the technic described by George Gray Ward. The sac was dissected free as high as the utero-sacral ligaments and tied off. The utero-sacral ligaments were sutured together as far as the rectum and the hernial opening was closed, using interrupted silk. Levatorrhaphy was done.

Convalescence was uneventful and she has had no recurrence.

Case 2 presents uterine prolapse with cystocele, rectocele and posterior enterocele.

Case 2.—Mrs. E. S., white, aged thirty-nine years, complained of a sense of pelvic pressure and weakness, backache and vaginal discharge. These symptoms began with the first delivery about 16 years ago and became worse with each of the four succeeding pregnancies. During the last six weeks she has had intermittent vaginal bleeding.

Examination revealed an obese woman with no pertinent findings except those referable to the pelvis.

Pelvic examination revealed a marked laceration of the perineal muscles; the uterus was slightly larger than normal and dropped downward as far as the levator muscles. There was a severe laceration of the cervix with edema and redness; there was a large cystocele and rectocele, the latter extended upward to the posterior fornix.

Operation was performed August 20, 1936. A vaginal hysterectomy was done, using the Mayo technic for the repair; silk was used to fix the broad ligaments to the symphysis pubis on either side. During operation the enterocele was demonstrated to make up about one-half of the "rectocele" mass and it was repaired with silk, using the technic of George Gray Ward. The patient has had no further trouble.

Discussion

Posterior vaginal hernia or enterocele, electrocele, hernia of the cul-de-sac of Douglas and high rectocele are the more common terms used in the literature to designate a herniation that extends through the cul-de-sac into the area between the rectum and vagina. Enterocèles are frequently unrecognized or are mistaken for rectocele. The successful repair of enterocele differs from that of rectocele because of the anatomy involved. Enterocèle is not frequently reported and only in the last six years have standard textbooks described the condition. Bueerman in 1932 found only 81 cases during an exhaustive search of the literature; he added three cases. Masson reported eleven new cases in the same year and since then to October, 1938, nine additional cases are mentioned. Since Garengoet reported the first case in 1736, the total number is eighty-seven cases. Without doubt the incidence of enterocele is far above this figure.

Etiology

A congenital defect in the structural development of the parts is the primary etiological factor. Zuckerkandl, Moschowitz, Jones and others have shown that a deep cul-de-sac is always found with enterocele. The secondary factor is trauma which is initiated by parturition in 90 per cent of the

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cases. Operation, contusion and intra-abdominal pressure brought on by severe exertion, ascites, tumor, etc., are the less frequent causes.

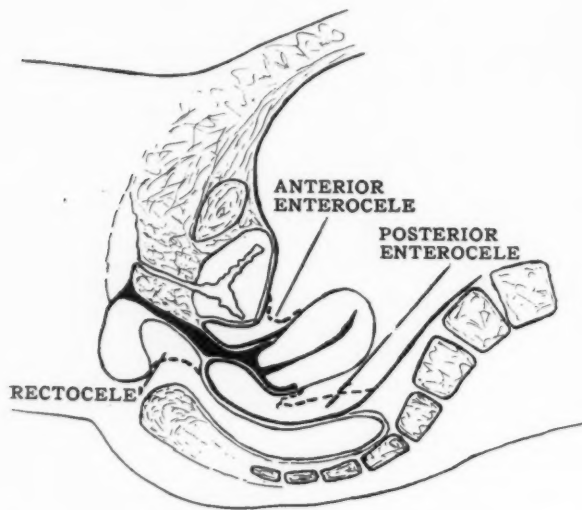


Fig. 1

Posterior enterocele is only one of a group of herniæ that project into the vaginal canal or at its orifice. (See drawings.) Herniæ about the vagina may be divided into two groups, the common and the uncommon varieties. Cystocele and rectocele comprise the first group and need no discussion here.

In the second group there are four varieties:

1. Posterior enterocele comprises 74 per cent of the cases, according to Bueerman. This hernia may project downward as far as the levator muscles.
2. Anterior enterocele projects through the anterior cul-de-sac between the bladder and the uterus and comprises 20 per cent of these cases.
3. Pudental herniæ project through the broad ligament just lateral to the uterus and appear in the lateral wall of the vagina or pudenda.
4. Ischio-rectal herniæ project through the levator muscle near the "white line" and appear lateral to the rectum; they are quite rare.

Symptoms of enterocele are not characteristic and are similar to those related to rectocele. The gradual appearance of a mass, the associated pressure upon neighboring organs and various degrees of local

discomfort are the usual signs. In about one-third of the cases the onset is sudden and in three cases reported signs of intestinal obstruction appear. The prone posi-

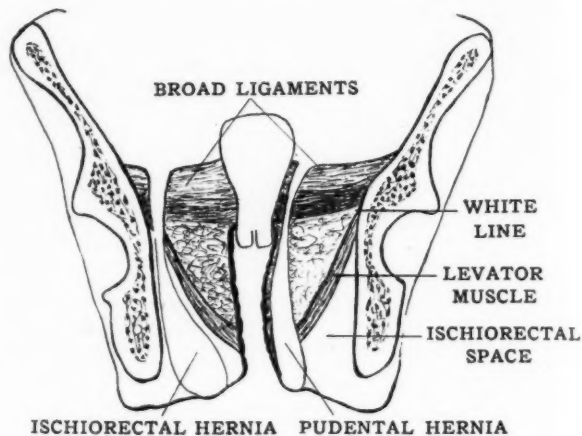


Fig. 2

tion may relieve all symptoms. The recurrence of a mass following a perineal repair or a hysterectomy is very suggestive.

Diagnosis is best established by reducing the hernia by rectal approach and preventing its return by pressure of the finger against the neck of the sac at the cervix. In large enteroceles peristalsis may be seen.

The indications for repair are as follows:

1. Active symptoms similar to those found in pelvic prolapse.
2. Steady increase in size of the hernia.
3. Signs of intestinal incarceration.
4. Discovery of the condition during the repair of perineal lacerations or uterine prolapse.
5. For prophylaxis against such reported complications as interference with parturition, rupture of the hernia with evisceration and injury to the bowel due to faulty diagnosis.

In about 46 per cent of Bueerman's series no operation was done and in seven cases (11.8 per cent) the condition disappeared spontaneously following delivery or pelvic infection.

Treatment of enterocele is surgical and one of two methods is chosen. The Moschowitz technic closes the cul-de-sac by the abdominal route by using a series of superimposed purse-string sutures of silk or linen.

The Ward technic employs the vaginal

approach and removes the sac as high as the uterosacral ligaments, which are sutured together as far as the rectum, and then the canal is closed by interrupted sutures. Unless there is complicating pathology that cannot be approached through the cul-de-sac, I believe that the latter technic is to be preferred, not only by the surgeon but also for the benefit of the patient.

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A RÉSUMÉ OF QUINIDINE SULPHATE THERAPY

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Quinidine was brought to the attention of the medical fraternity twenty years ago. Its earlier champions^{7,12} held forth brilliant possibilities for the drug in the treatment of irregularities of the heart beat. Later clinicians^{4,10,15} have used the drug with increasing respect, both for its therapeutic value and for its irregular toxic effects. Although quinidine is not the panacea for irregularities that we had first hoped it might be, it has become a definite aid to us in the control of certain factors in heart disease and has added another rung to the ladder of knowledge of heart physiology.

Quinidine sulphate is derived from cinchona and is the dextroisomer of quinine.³ Quinidine is less of a protoplasmic poison than quinine and is less effective in the treatment of malaria.

Quinidine sulphate exerts its action by increasing the refractory phase of contracting heart muscle.⁶ It is said⁶ to have the ability to depress the property of irritability of heart muscle, but the term "depressed irritability" does not seem proper in light of the physiology of cardiac muscle. By lengthening the refractory phase of myocardium it causes extra-nodal foci of excitation to fall upon the heart muscle when it can not respond to stimuli other than those coming over the conducting system at the proper interval. Fortunately quinidine has little or no effect upon the sinus node and by the same token should not be used to correct a sinus tachycardia. It has little or no effect upon the tone of heart muscle.

Its more common toxic manifestations,^{5,17} which are in the vast majority of cases due to excessive doses, are tinnitus, nausea, vomiting, headache, diarrhea, skin rashes, and, rarely, sudden death.

Because of the antagonistic action of digitalis and quinidine they are often used in conjunction with one another, but there is no logical reason for this. It has been shown^{5,18} that while quinidine will prevent some of the toxic arrhythmias produced by

digitalis, when both drugs are used together there are electrocardiographic changes produced which are not found when either drug is used alone. There should be little objection to slowing the rate of fibrillation, in some cases, with digitalis prior to the administration of quinidine, providing the patient has not been over-digitalized.

Digitalis definitely increases tone and contracting ability of heart muscle and also increases the conduction time over the bundle of His. Quinidine has little or no effect on these phenomena.¹⁷

Quinidine is indicated in cases of paroxysmal auricular fibrillation, both to stop the attacks and lessen the frequency of their occurrence.^{11,12,13} The optimum dose is twelve to forty grains a day for not more than seven or eight days, following a sensitizing dose. In uncomplicated cases we are led to believe that we may expect a return to normal rhythm in about 50 per cent of trials. It is agreed^{4,5,11,15} that the best results are obtained in patients who have not been fibrillating more than a few months, who have no evidence of decompensation or heart failure, who have no sign of cardiac pathology, and who have not had embolic phenomena.

There has been a great difference in opinion regarding the dangers of quinidine in cases of established fibrillation. The two

principal hazards are syncope and embolism due to dislodging of a clot from the auricles. Fatalities due to quinidine are rare but a number of sudden deaths have been reported from reliable sources.¹⁷ In cases of long standing fibrillation it seems questionable whether the benefit of temporary return to sinus rhythm justifies the exposure of the patient to the large doses usually required.

It is generally agreed^{1,5} that it is unsafe to administer quinidine to thyrotoxic patients sooner than ten days following thyroidectomy, because thyroxin is stored in excessive amounts in the myocardium up to that time at least and this makes the action of quinidine uncertain.

Quinidine should be tried in cases of auricular flutter.^{8,9,11} While digitalis is still held as the more effective remedy by some, the attacks may be lessened in frequency and in duration in most cases by not more than nine grains a day for four to six days.

Paroxysmal tachycardias of both auricular and ventricular types are definitely benefited by the use of quinidine.¹¹

There is less general agreement as to the beneficial effects of quinidine in the cases of extrasystoles. The most logical argument in favor of quinidine is that it tends to lessen the probability of a more serious arrhythmia.¹⁴ Bohan⁵ reports the successful use of quinidine in ambulatory cases by the administration of six to nine grains a day for four days followed by a rest period of three days before repetition.

Quinidine is becoming increasingly important as a therapeutic agent in the treatment of myocardial infarction.^{5,11,16} The cause of death in these cases is usually fibrillation of the ventricles. Many writers advocate the use of five grains four times a day from two to six weeks to prevent any fatal arrhythmia during the recovery period. Quinidine should also be given in cases of angina pectoris when attacks are frequent, not to stop pain, but to prevent ventricular fibrillation.^{8,11}

In conclusion:

1. Quinidine is of definite value in the therapy of uncomplicated paroxysmal auricular fibrillation and in paroxysmal tachycardias of both auricular and ventricular types.
2. It may be of value in cases of long standing auricular fibrillation and of auricular flutter, and in the therapy of extrasystoles.
3. It may be of value in cases of myocardial infarction and angina pectoris by preventing the occurrence of a fatal arrhythmia.
4. It will not correct a sinus tachycardia.

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*"Every man owes some of his time to the up-
 building of the profession to which he belongs."*

—THEODORE ROOSEVELT.

EDITORIAL

CUT RATE PHYSICAL EXAMINATIONS

A new federal law makes it mandatory that all truck drivers engaged in interstate commerce submit to and pass satisfactorily physical examinations. These are presumably to be the responsibility of the employer, to be paid for by him. A new agency has been organized to assist the employer by providing him with the necessary forms, data and advice required by the new law. There is no particular objection to this. We understand, however, that while, as mentioned, the selection of the doctor and payment for his services is the function of the employer, the service organization mentioned is in a position to recommend physicians and actually does this. Furthermore, that physical examinations are actual-

ly being made for a dollar each and sometimes for less. The physical examination blank has been examined by the medical economics commission of the Wayne County Medical Society, who maintain that a proper filling out of the form requires as much time and care as entailed in an ordinary life insurance examination.

How an experienced professional man can make these examinations for a dollar is difficult to comprehend. As charity, he often gives his services, but this is not a matter of charity. The truck driver may require a passport photo as a means of identification. All taxi drivers do. If so, he will pay at least a dollar for his photo by a photographer whose skill and training and responsibility do not compare with that of the doctor.

The physical examinations are for the sake of greater safety on the highways. Why then should not the matter be taken seriously? Why enter into any agreement the proper carrying out of which is apt to lead to cheap and slipshod work? If the laborer is worthy of his hire, why is not the physician also? The term "cut rate," wherever one encounters it, leads to the suspicion of inferiority. After all, one usually gets what he pays for, sometimes less, seldom more. The federal law requiring the physical examination of truck drivers was enacted for the purpose mentioned. Why render it useless by treating it as if it were an unimportant piece of legislation that may be dispensed with in the most routine way?

THE LAY PRESS

The November number of *Fortune* contained an article on the American Medical Association; and, by the way, let each reader of the JOURNAL of the Michigan State Medical Society not lose sight of the fact that this refers to him as a member of the great body of organized medicine in the United States. The article in *Fortune* is based upon "three months of research," the conclusion of which is that "the American Medical Association has worked against its own purposes by changing to ideas that have been discredited. Today it finds itself within hailing distance of its own downfall and it is now in a process of acknowledging defeat of its leadership."

Some wise person has said that the apple tree with the finest fruit is that which has

the most clubs lying on the ground around it. If there is any truth in this, the medical profession can certainly take heart over the attention it has received in the past few years.

Prior to the appearance of the November number of *Fortune*, many physicians throughout the United States, including the editor of this JOURNAL, received letters drawing attention to the forthcoming article on the medical profession. Dr. Andrew P. Biddle, who is one of the best known men in Michigan medicine, has written a reply to said letter after reading the article in *Fortune*. Dr. Biddle's letter is very much to the point. He speaks from an experience of over half a century, which surely is entitled to a hearing as compared with "three months' research." Dr. Biddle emphasizes the personal relationship between patient and physician, and goes on to say that the analogy often made between medical service in the army and medical service to the lay population is beside the point, owing to the fact that both soldier and sailor and medical staffs of the army and navy are under military and often wartime discipline. In reply to the statement that the medical profession had not yet removed the preponderance of many diseases, among them syphilis, Dr. Biddle makes the emphatic statement that "there is no comparison in what constituted care of syphilis at the time of my graduation in 1886 and what it is today. The case is as different as night and day." Everyone would agree to this even though his experience may not have gone back farther than two decades.

Dr. Biddle deplors the attitude of many younger physicians "who grasp at a fancied economic security and sell their soul for a temporary appeasement." There are reasons for this which we will not discuss.

Dr. Biddle makes a strong point in the following paragraph:

"In reply to your letter I cannot understand why you editors would inflict upon others socialized medicine, governed by bureaucratic politicians, who know nothing of medicine and the sick and care less, that which you would not impose upon and submit to yourself. You are insistent upon the freedom of the press. Why deny us freedom of thought and action?"

Yes, why are some editors so insistent on maintaining the guarantee of the constitution regarding the freedom of the press and

at the same time evince a willingness to impose regimentation on the medical profession? We hesitate, however, to indict the entire press, for the simple fact that a large number of editors do champion that freedom for others that they insist upon for themselves.

Dr. Biddle goes on to say "there are conditions which effect the general public and which cannot be handled except through public agencies; but these conditions do not usually apply to the individual." Every rational person will concede this.

The reader is reminded that medical ethics, which has come in for so much obloquy, has come down through the centuries to define a working behavior towards the patient, towards the public and among doctors themselves and has, therefore, a survival value. Dr. Biddle goes on to say that "some of its principles are fundamental and eternal. Others are liquid and are changed from time to time to meet the changing conditions of human relations. In conclusion, the doctor wisely maintains that "we shall not submit to mass regimentation so long as we have to force to endure."

A NEW CIRCUMCISION TECHNIC

In an attempt to simplify the operation of circumcision an instrument consisting of two parts is used. The first is a spindle-like part having bell-shaped ends of a large and a small size. Around each end is a groove into which the wire ring of the second part contracts. The spindle is hollow,

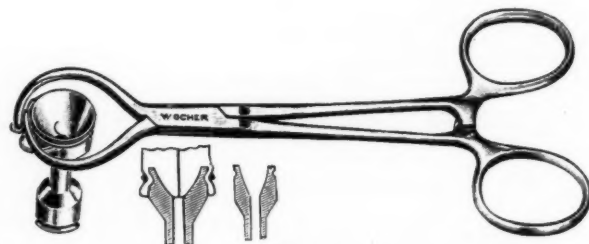


Fig. 1

to prevent a vacuum attaching the instrument to the glans, and to permit escape of urine in case a baby should void during the operation. The second part is like a hemostat with curved beaks into which is fitted a wire ring which expands and contracts as the instrument is opened and closed. As the beaks open, the wire ring opens on one side to permit it to be slipped onto the spindle from the side rather than over the end.

In changing the instrument to a different size the opposite end of the spindle is used and the wire ring is replaced by one of the other size, a procedure which is as quick and easy as changing the wire in a tonsil snare. However, unless it is necessary to change sizes, the same wire does for an indefinite number of circumcisions. The smaller size

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EDITORIAL

is suitable for boys from birth to six or seven years of age, and the larger size for older males.

The circumcision is performed by making a dorsal slit and freeing the adhesions between the prepuce and the glans. The prepuce is then stretched over the bell-shaped end of the spindle and held in place by the thumb and index finger of the left hand while the wire ring clamp is slipped onto the spindle at the level of the groove with the other hand. The wire ring is then contracted, crushing the prepuce into the groove. The instrument is left in place about ten minutes, after which the prepuce is trimmed off close above the wire with a scalpel and the instrument removed. Usually no suturing is required and no bleeding occurs.

The advantages of the technic are: it facilitates the operation, it saves suture material, and the completed operation is smoother.

E. M. SMITH, M.D.
16 Monroe Ave.,
Grand Rapids, Mich.

WHO IS LIABLE FOR TAX

Operators of private laboratories, private sanitariums, and physicians employing one or more were advised today by Commissioner of Internal Revenue Guy T. Helvering to make immediate tax returns as required under the provisions of Titles VIII and IX of the Social Security Act to avoid further payment of drastic penalties which are now accruing.

Commissioner Helvering pointed out that every person involved in such work came under the provisions of Title VIII, which imposes an income tax on the wages of every taxable individual and an excise tax on the pay roll of every employer of one or more. This tax is payable monthly at the office of the Collector of Internal Revenue. The present rate for employer and employee alike is one per cent of the taxable wages paid and received.

Under Title IX of the Act, employers of eight or more persons must pay an excise tax on their annual pay roll. This tax went into effect on January 1, 1936, and tax payments were due from the employers, and the employers alone, at the office of the Collector of Internal Revenue on the first of this year. This tax is payable annually, although the employer may elect to pay it in regular quarterly installments.

The employer is held responsible for the collection of his employee's tax under Title VIII, the Commissioner explained, and is required to collect it when the wages are paid the employee, whether it be weekly or semi-monthly. Once the employer makes the one per cent deduction from the employee's pay, he becomes the custodian of Federal funds and must account for them to the Bureau of Internal Revenue.

This is done, Mr. Helvering said, when the employer makes out Treasury form SS-1, which, accompanied by the employee-employer tax, is filed during the month directly following the month in which the taxes were collected. All tax payments must be made at the office of the Collector of Internal Revenue in the district in which the employer's place of business is located.

Penalties for delinquencies are levied against the employer, not the employee, the Commissioner pointed out, and range from 5 per cent to 25 per cent of the tax due, depending on the period of delinquency. Criminal action may be taken against those who wilfully refuse to pay their taxes.

The employers of one or more are also required to file Treasury forms SS-2 and SS-2a. Both are informational forms and must be filed at Collectors'

offices not later than next July 31, covering the first six months of the year. After that they are to be filed at regular quarterly intervals. Form SS-2 will show all the taxable wages paid to all employees and SS-2a the taxable wages paid each employee.

AMERICAN MEDICO-LEGAL ASSOCIATION

We have received Number I, Volume I, of the *American Journal of Medical Jurisprudence*, the official organ of the American Medico-Legal Association, with offices at 137 Newberry Street, Boston, Massachusetts. Dr. Frederick C. Warnshuis, formerly secretary of the Michigan State Medical Society, is the editor. Dr. Warnshuis is also president of the American Medico-Legal Association. The journal is unique in its appeal to the professions of Medicine, Law and Dentistry. The editorial board comprises nineteen of the most outstanding authorities on medical jurisprudence in the United States. The journal consists of seventy-two double column pages of reading matter in good, clear type. The purposes and scope of the work of the new association are as follows:

(a) To edit and publish the *American Journal of Medical Jurisprudence*;

(b) To assume leadership in the conducting of an educational movement directed to bring dependable information to physicians, dentists, hospitals, attorneys, employers and employees upon questions relating to the legal provisions governing the rendering of professional services;

(c) To inaugurate movements, to mold sound opinions and to establish unity of standards and action in medico-legal relationships;

(d) To devise ways and means to inspire and encourage investigations in the field of Forensic Medicine.

(e) To aid medical examiners and coroners;

(f) To assist law enforcement officers in perfecting standards of medical examinations required by law;

(g) To provide a central office of information on medico-legal questions;

(h) To assist members in their indemnity insurance problems;

(i) To develop studies, conduct research and to advance regulations in employment compensation; and

(j) To concern ourselves with any and all of the branches of legal medicine as they are related to the rendering of medical care and preventive medicine.

A good idea of the new journal is to be had from a perusal of the contents of the present number: The Medical Man on the Witness Stand, by Eugene O'Dunne, LL.M.; Blood Groups in Disputed Paternity, by Michel Pijoan, M.D.; What Constitutes Body Attack in Medical Practice? Herbert V. Barbour, LL.B.; The Expert Witness and the Insanity Defense Plea, Martin H. Hoffman, M.D.; The Interpretation of X-rays in Court Hearings, by L. H. Garland, M.D.; Organized Society's Interest in Death, Oscar T. Schultz, M.D.; Detailed Examination Required to Determine Whether Rape has been Committed, J. R. Garner, M.D.; Doctors, Juries, and Judgments, Paul E. Craig, M.D.; and Diagnosis and Treatment of Legal Congestion, by Alfred Koerner, M.D. In addition to these is an interesting and timely paper on The Coroner and the Medical Examiner, prepared by the National Research Council of the National Academy of Science. Then follow special departments, namely, Editorial, Across the Editor's Desk, in which the editor assumes a more personal approach to his subject, Current

Comment, In the Courts, In the Legislature, Open Forum, Book Reviews and Abstracts.

Number 1, Volume I, is of absorbing interest. It sets a high standard for succeeding numbers. The editor's long experience as secretary of the Michigan State Medical Society and editor of its Journal, as well as his years as speaker of the House of Delegates of the A.M.A., admirably qualify him for this latest venture in specialized journalism.

SHOULD RADIOLOGY AND PATHOLOGY BE INCLUDED AS BENEFITS IN HOSPITAL INSURANCE PLAN?

Radiology and pathology are definite, legitimate specialties and their practitioners are consultants, possessed of much highly technical post-graduate training and are entitled to an equal consideration and standing accorded to those engaged in other recognized specialties. There is no justification in forcing them into the degraded roll of "come-ons" or their services offered as additional inducements for the purpose of increasing policy sales.

Not more than ten per cent of legitimate hospital patients require any form of x-ray and only twelve per cent require any but the simplest laboratory investigations, hence, there is very little total benefit to policyholders. Would it not be more sensible to give them an additional day or two hospitalization? The inclusion of *some* professional services will most certainly pave the way for the inclusion of more and broader practice of medicine by hospitals, as was so graphically pointed out in an editorial in the State Journal a few weeks ago. This would destroy more and more the age-old doctor-patient relationship which is the fundamental basis for all good medical practice.

It is argued that charges for x-ray and pathological services are now commonly included in the hospital bill and the patient will expect them to be included in benefits. It seems to us that this is a rather inane argument. Charges for oxygen, insulin, unusual dressings and drugs, board for special nurse, etc., are also included in a hospital bill, but all plans very definitely class these as extras and they are not included in benefits.

The success of a hospital insurance plan does not depend on x-ray and pathological benefits. The Baylor plan, one of the oldest and continuously most successful of all plans, does not and never has included professional services in any form or guise. In Wichita, Kansas, and Nashville, Tennessee, there are thousands of policyholders who pay extra for x-ray and pathological charges, if, when, and as needed. There are numerous other such plans equally successful, working with full coöperation of the medical profession and giving only true hospital expense coverage. These are the reasons why organized radiology and pathology, including all national organizations, are vehemently opposed to being included as benefits. In this they are strongly supported by the published policy of the A.M.A.

Insurance coverage for medical attention in accident and sickness is another separate and distinct matter and may eventually be worked out in a manner which will prove to be feasible. A definite advance was made in this direction as presented in the Mutual Health Service plan submitted in 1934, which we would do well to consider carefully. When the time comes the services of the radiologist and the pathologist will naturally be included on the same basis of the practice of medicine.—*Genesee County Medical Bulletin*.

WARNED IN TIME

["Herr Julius Streicher, addressing a thousand members of the Nazi Welfare Medical Administration at Munich, suggested that Herr Hitler and Signor Mussolini were great because they were non-smokers."—News item.]

Tobacco is a noisome weed (Herr Streicher he has said it),
And from its victims there proceed no men of worth and credit;
Though Bismarck puffed, and even snuffed, and kept cigars a-going,
He was a dud—his name is mud on Streicher's latest showing.

The men of State, the good and great, avoid those hideous vapours;
Their names appear all bright and clear on History's page and papers.
Tobacco jars and fat cigars both fall beneath their veto;
They scorn all types from fags to pipes, like Adolf and Benito.

And yet beware—if that bright pair of dictatorial jokers
Now represent the mood and bent achieved by staunch non-smokers,
Why, some may flock to fill, restock their smoking store or larder,
Resolved to miss that doubtful bliss by smoking all the harder.

—*Manchester Guardian*.

PARIS PHYSICIANS PROTEST AGAINST SOCIAL INSURANCE

The abuse of free medical care by the public hospitals and dispensaries and the illegal extension of the original function of the social insurance authorities are arousing the French medical profession to make a virgorous campaign to put an end to a movement which renders it difficult for physicians to earn a living, the regular Paris correspondent of *The Journal of the American Medical Association* reports in the Dec. 10 issue. In the notice sent out by the association of physicians in the department of the Seine, in which Paris is situated, for a meeting to be held Nov. 4, 1938, the following plea was made for a full attendance:

It is becoming more and more difficult, in fact almost impossible, to practice in Paris and the adjacent areas.

The public hospitals and dispensaries, which are not subjected to the excessively high taxes which physicians must pay, are doing all they can to give free medical attention without any inquiry as to the ability of the sick to pay. Such institutions should treat only indigents.

The social insurance organization was created to insure the worker earning up to a certain sum annually, now 30,000 francs, so that he might be able to pay for medical care. Instead of limiting their activities to this commendable objective, the social insurance authorities have begun to make serious inroads on the work of private practitioners by attempting to organize facilities for treating the insured worker. Every effort is being made to turn the insured from specialists and general practitioners by urging them to enter public hospitals or receive treatment at the many public dispensaries.

The situation has become so acute that the time has arrived for a more energetic campaign against these abuses, which make it impossible for a physician, after many years of preparation, to compete with the tendency toward state medicine.

President's Page

EN ALERTE

TO BE ALERT, to be aware, to be prepared for the duties ahead is winning more than half the battle.

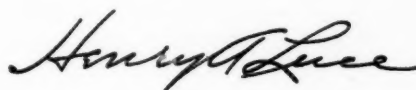
By the time this page reaches the membership, it is anticipated that the House of Delegates will have taken positive action covering some phases of the medical problems. However, this is only a small part. We are continually faced with numerous attempts to experiment with the distribution of medical service. It can be reasonably anticipated that much medical service legislation will be under consideration this session of the State Legislature. Efforts to modify the basic science law, changes in the afflicted child law, provisions for medical relief to governmental assistance groups, extensions of Public Health Departmental activities and numerous other topics are definitely on the legislative programs.

Any developments that may occur must be patterned after American methods, individual responsibilities and free enterprises.

Your State Society officers and committees are working endless hours and sacrificing health and means with two objectives in view. The first is that the distribution of medical care to the people of the State of Michigan be of the best quality and adequate for their needs. The second, that the economic security of the physician, opportunity to improve his scientific knowledge and his welfare be adequately safeguarded because the physician is the keystone of the Arch of Health and without a sturdy keystone the arch will fall.

It is the duty of every member of the Society to inform himself thoroughly of all activities involving the health of the public, to be alert to the possibilities of legislation inimical to the general welfare, and to contribute his share personally towards attaining our objectives. Do not leave the task to the Legislative Committee alone—make yourself a committee of one herewith appointed by

Yours truly,



President, Michigan State Medical Society

MEDICAL STAFF CONFERENCES

"The Department of Internal Medicine is this year (1938) inaugurating a series of weekly Medical Staff Conferences, the first of which was held in the Hospital Amphitheatre on October 7 at 4:00 P. M. These meetings are to be attended by all the members of the staff of the department and they are also open to members of other departments, the faculty of the Medical School and visiting doctors. The conferences are not open to medical students except by special invitation.

"The present arrangement is to have two patients from the Medical Service presented at each conference. These patients are selected at a weekly meeting of the Assistant Residents from the various Medical Wards and the Tuberculosis Unit and the Intern at Simpson Memorial Institute with Dr. Bert Bullington. Interesting cases from the Out-Patient Department may also be suggested by any member of the staff. A brief abstract of the history, physical examination and laboratory data is prepared by the physician in charge of the patient and mimeographed copies are distributed at the Conference. The meetings are presided over by Dr. Cyrus C. Sturgis, or in his absence either by Dr. Henry Field, Jr., or Dr. Paul S. Barker. All the discussion in regard to each patient, including all relevant references to recent and important literature, is recorded, typed and attached to the patient's record."—*University of Michigan Medical Bulletin*.

Medical Conference, October 7, 1938. Patient, G. P., No. 429756. Presented by Dr. Kenneth M. Smith.

DR. CYRUS C. STURGIS: The earliest symptom was pain in the eyes followed by swelling which completely closed them. At that time she also had fever. It was because of these symptoms that she came to the University Hospital and was admitted to the Eye Department. The ophthalmologist asked for a neurological consultation, but no neurological lesion was found, whereupon she was referred to the Department of Internal Medicine for examination. Dr. Howes, who saw her, suspected trichinosis, although no differential blood count was available at that time. She was then transferred to Medicine. Her temperature had been between 101.8 and 102.8 degrees (F.), gradually decreasing to normal on the third hospital day.

DR. KENNETH M. SMITH: On October 4, 1938, the patient had a tonsillectomy (because of a chronic tonsillitis). The pathology report (by Dr. Weller) described areas of focal myositis with eosinophilic infiltration, pathognomonic of trichinosis. Another specimen showed encysted trichinella spiralis in the pharyngeal muscles.

DR. CYRUS C. STURGIS: The blood examination on the 6th of October showed a white blood count of 6,800 with 26.5 per cent eosinophils. She is now recovering very satisfactorily, she looks well, and there is no muscle soreness. At first the muscle soreness was very severe, so much so that it was painful for her to straighten out her legs. The presence of muscle soreness, puffiness of the eyes, fever and eosinophilia at once suggests the diagnosis.

The reasons for presentation today are: In the first place, this is the third case of trichinosis that we have seen in the last few months. One very interesting case recently seen, which came to autopsy, showed the presence of trichinae throughout the body, including the myocardium. The second reason is that we have used the skin test as a diagnostic measure. This test is very simple to perform, it can be read easily, an area of induration with surrounding erythema indicates a positive result. This test is helpful in the diagnosis because about 50 per cent of the muscle biopsies in these cases are reported as negative. Dr. Bullington has collected considerable data concerning this disease in cases seen in this hospital since 1926.

DR. BERT M. BULLINGTON: Dr. Field has seen most of these cases. Since 1926 there have been forty-two cases recorded in the Record Room. Of these there were thirty-one active cases; six were diagnosed as incidental findings in the pharyngeal muscles removed at tonsillectomy and two of these

cases diagnosed by tonsillectomy were active at the time of tonsillectomy. Four cases were diagnosed by incidental muscle biopsy findings (the biopsies being performed for some unrelated illness). Three cases were picked up as incidental autopsy findings (the patients having died of some unrelated illness but having active trichinosis at the time of death). Thirteen were diagnosed by the clinical findings only, the clinical picture being quite definite. The clinical impression was confirmed by muscle biopsy in nine others; two by the skin test plus the clinical picture; one by the skin test and biopsy specimen; one by the clinical picture in addition to finding the trichinae in a specimen of pork submitted by the patient; one was diagnosed by the finding of the larvae in the venous blood; one by the presence of the parasites in the stool; and one by the presence of the trichinae in the spinal fluid.

Of these thirty-one active cases, twenty-eight had an eosinophilia ranging from 15 to 73 per cent. One active case had an eosinophilia of only 4 per cent; two had no differential counts done. In these cases thirteen muscle biopsies were done, two on the same patient; ten were positive for the diagnosis; two were suggestive of the diagnosis, and one was negative—which is not in harmony with reports from the literature that more than 50 per cent of muscle biopsies are negative.

We have done but four skin tests. Three were immediately positive and one questionable reaction; that reaction was not read until twenty-four and forty-eight hours, at which time erythema was present at the site of the injection. Three patients had meningitis—that is, trichina meningitis. One of these patients with meningitis recovered. Two patients had myocarditis, as evidenced by electrocardiographic studies, two had myocarditis shown by the pathological specimen. One had repeated hemoptyses, one had a terminal hemorrhagic state, and died after a brisk hemorrhage from the ears, nose and mouth. At autopsy a subdural hematoma was found. One patient had a false positive Kahn on two occasions; two Kahn reactions later were negative.

DR. CYRUS C. STURGIS: Dr. Smith, do you have information regarding the Federal regulations controlling pork inspection?

DR. KENNETH M. SMITH: The Federal regulations at the present time are not very stringent. It is required, however, that all pork products which are to be eaten uncooked have to be boiled, by the producer. This is particularly true of ham, which must be heated to 137°F. Trichinae are killed by a temperature of 58°C. Pork is not directly examined for trichinae, hence the stamp of "U. S. Inspected and Passed" means nothing insofar as pro-

MEDICAL STAFF CONFERENCES

tection against trichinæ is concerned. It is, therefore, advisable to cook all pork well.

DR. STURGIS: This disease is not so uncommon. Are there any data about the study of muscle tissue in routine autopsies in patients who have died of various diseases?

DR. KENNETH M. SMITH: There is considerable amount of work that has been and is being done in this respect. In a series of 200 routine autopsies in San Francisco, trichinæ were found in 23 per cent of the cases; 344 autopsies in Rochester showed an incidence of 7.5 per cent; in Boston 27.6 per cent of fifty-eight autopsies; and in a recent study in Washington of 300 cases the incidence was 13.6 per cent.

Dr. Lloyd Catron has studied muscle specimens in 300 autopsies at the University Hospital. There had been no symptoms of trichinosis but trichinæ were found in 15 per cent of the specimens. There are many other similar statistics. Hall and Collins found an incidence of 12.5 per cent in 1,778 cases.

DR. CYRUS C. STURGIS: We might substitute the diagnosis of influenza for trichinosis for the lack of a better diagnosis in those individuals who have fever and muscular aching but no puffiness of the eyes.

Are there any data as to the death rate in this disease?

DR. KENNETH M. SMITH: The death rate in central Ohio epidemic of ninety-six cases was 8.3 per cent and in a Maine outbreak of fifty-six cases, two were fatal.

DR. CYRUS C. STURGIS: Have there been any experimental studies directed toward treatment?

DR. KENNETH M. SMITH: Bachman attempted immunization of rats against trichinella spiralis and found that only temporary protection could be given by feeding increasing dosages of infected meat. He also attempted to protect rats by injecting anti- and convalescent sera, feeding trichina powder, and by the intraperitoneal injection of a Coca's suspension of finely ground larvæ, but was unsuccessful in all attempts. Semrad exposed trichinella larvæ to x-ray irradiation (800 r units); although they were not killed they showed an inability to reproduce.

Miller studied a number of drugs which had been reported as therapeutically useful. Intravenous neoarsphenamine, antimony and potassium tartrate, acriflavine base, Rivalar, gentian violet and iodine had no therapeutic effect on experimentally infected animals.

Wantland found that cysts begin to form around the coiled larvæ, in the muscles, in four to six weeks; these cysts become calcified in seven to eight months. Symptoms arise from unencysted larvæ and death from trichinosis occurs within the first four to six weeks of the disease. We know that irradiated ergosterol increases the absorption of calcium from the intestinal tract. With this in mind he treated infected rabbits with calcium lactate and irradiated ergosterol. The calcification of the cysts was found to occur more rapidly, being completely so in 3 months instead of the usual period of eight months. The treated animals showed a return of their normal appetite much earlier than the non-treated ones.

DR. CYRUS C. STURGIS: Dr. Field, according to Dr. Bullington, saw most of the trichinosis patients in this hospital. Perhaps he has something to offer?

DR. HENRY FIELD, JR.: There are two patients that I recall that are of some interest. These two had presenting symptoms of fever and swelling of the lids. Both of them had no eosinophilia on admission. The diagnosis was suspected because of the association of fever with swelling of the lids with no other apparent cause of the edema. Repeated blood counts showed the development of eosinophilia. Therefore the absence of eosinophils on admission does not exclude the diagnosis.

I would like to know if there is any information about what the skin test would show in patients infected five to ten years ago?

DR. STURGIS: I believe Dr. Bullington has some information about how long the skin tests have remained positive.

DR. BULLINGTON: One report by Spink stated that some of the cases who gave a definite history of infection six to seven years ago, recently tested (in January, 1937), still had positive skin tests but the number of positive tests was low. Other individuals who ran tests on 82 cases in epidemic five years ago, found that all had negative skin tests.

DR. STURGIS: But it may be positive after several months or years?

DR. BULLINGTON: In all probability it is positive for several months and perhaps two to three years.

In December, 1936, and again in January and February, 1937, there were two rather severe epidemics in the state of Michigan: one at Rogers City and one at Capac. There were thirty-two cases at Rogers City and seventy-two at Capac. One of our patients came from Rogers City.

DR. STURGIS: What was the mortality?

DR. BULLINGTON: The only data available were from Capac. There were six fatalities; thirty-three severe cases; twenty moderately severe; thirteen mild cases.

We had one interesting family in our study. The father, who was very severely infected, died and the mother died of meningitis before she was admitted. There was one son on the medical wards, one daughter and one son on the pediatrics service; all had the disease quite severely.

DR. STURGIS: Can you tell us why there are two reactions to be expected—the immediate and delayed?

DR. BULLINGTON: The skin test is an allergic reaction. The antigen that we use is in two dilutions, 1:500 and 1:10,000, having been obtained from the Michigan State Department of Health. This is an extract of the trichinæ in Coca's solution. A control of Coca's solution should always be used. In cases of a duration of 18 days or longer an immediate reaction is expected, becoming positive within a few minutes and usually disappearing after two hours. If the disease is of shorter duration—four to twelve days—a positive reaction is to be expected only after twenty-four hours without any immediate reaction.

DR. STURGIS: What is the composition of Coca's solution, Dr. Sheldon?

DR. JOHN M. SHELDON: Coca's solution contains 2.5 grams sodium bicarbonate, 4 grams phenol and 5 grams of sodium chloride made up to 1,000 c.c. with distilled water.

DR. STURGIS: At a medical meeting last year, Dr.

MEDICAL STAFF CONFERENCES

Fred Smith reported a series of cases of myocarditis. He showed some sections supposedly having an obscure etiology. Dr. Weller, who was present, suggested that it appeared to be trichinosis of the heart.

DR. ARTHUR C. CURTIS: A few years ago, a small epidemic of trichinosis occurred in St. Joseph, Michigan. Dr. Kerlikowske and I happened to be in St. Joseph at that time. The members of one family that we saw were very ill. The onset of the illness had been with a high fever and a very severe diarrhea. They were being treated at that time as influenza. The blood differential count did not show an eosinophilia during the early period. When an eosinophilia developed, the local physician suspected the diagnosis and asked me to see the case. It was the most severe type of the disease, with profound diarrhea and considerable contracture of the muscles of the extremities. This latter feature was so great in the father, who was very well muscled, that he lay in a position as if he held heavy weights in each hand. His neck was also rigid. The father died, as did the mother. Only one survived, that being a young boy. Their temperatures were 105-106° F.

Diarrhea seems to be an index to extent of invasion. Minor invasion may occur without diarrhea.

DR. BULLINGTON: One patient in our series had Hirschsprung's disease. At autopsy his entire intestinal tract was heavily infested with trichinae.

Anti-vivisection Again (New York Times)

It is an honorable medical principle that before a new method of treating disease is introduced it must be tested not only on animals but on animals closely related to man. To adopt any other procedure is to slip back to the Middle Ages, when even the dissection of cadavers was forbidden. Diphtheria, syphilis, pneumonia, pellagra, pernicious anemia, smallpox, all the afflictions caused by deficiencies in vitamins and hormones or by bacterial infection would still be insoluble riddles if it had not been for researches carried on with the aid of dogs, guinea pigs, rats and monkeys. If ever cancer and tuberculosis yield to medical treatment it will be solely because biologists and chemists have put their theories and their preparations to the test on animals. A billion rats is no price at all to pay for even the dimmest light on the cause of cancer.

Despite these oft-presented facts the anti-vivisectionists are making a new attempt to thwart experimental medical research, this time in California. There the voters will be asked on Nov. 8 to ballot on what is called a "humane pound law." Any one who keeps animals, except for sale, will become a "poundmaster." As such he may not use domestic animals for experimentation. If this proposal is approved the laboratories will have to breed their own animals, a procedure which is impractical because of the numbers that are needed. Moreover, it will be difficult for the makers of vaccines, vitamins, hormones and chemicals for medical use to test their products before placing them in drug stores, with the result that physicians could not be sure of the efficacy of the medicines that they prescribe. That thousands of half-starved, uncared for and unwanted dogs roam the streets and back yards to fall a prey to official dog-catchers and meet death in city pounds seems to be ignored.

"If you do not kill this measure it will kill you" is one of the slogans under which California biologists and medical men are fighting the "humane pound law." And the slogan is true. Interference with the right to reduce human suffering and to

lengthen the span of life by the most effective way thus far discovered is suicidal. Between dogs and babies the choice is easy. "An intelligence test for voters" the Californian measure is called by its sponsors. If there is any intelligence in California it will meet the test by repudiating a device for checking medical progress.

For Early Diagnosis of Cancer of the Cervix (New York State Journal of Medicine)

It is in this sense that we can consider the Schiller test for the detection of early cancer of the cervix. Following exposure of the part and cleansing, a generous quantity of Gram's solution is applied to the cervix and permitted to stay in contact with it for at least five minutes. Differentiation between normal and cancer cells is demonstrable by the deep brown color of the former, in contrast to the lighter color of the latter, which appear as whitish spots. This reaction is the result of the glycogen deficiency of cancer cells. According to De Lee, also Watkins, this test should be performed on women in middle age at least once yearly.

When it is realized that the incidence of cancer of the cervix is second only to mammary cancer, this simple test is a distinct advance in early diagnosis. By this means, treatment can be instituted at the earliest possible time and an increase in the number of "cures" can be hoped for. The simplicity of the test makes it readily applicable by the general practitioner.

Election Portents

(New York State Journal of Medicine)

It is true that the outcome of the elections may give thought to the Administration in Washington and persuade it to reform the reforms it has already instituted before undertaking additional hastily concocted experiments. If counsels of moderation prevail, there is hope that the profession will be given an opportunity to work out a sound, long-range plan in conformity to actual needs. The fact that the nation's health keeps reaching a new high, year after year, denies the existence of an emergency and proves that the present system is neither obsolete nor incapable of adaptation to new conditions and requirements.

Whatever the course followed at Washington, New York State should stand firm on the principles which have given it first place in public health. It leads the rest of the country in this field because it has kept the medical profession as its chief health adviser. Let it abandon this qualified counselor for inexperienced social theorists and it will become entangled in costly bureaucratic schemes which will lower the comparatively high standards of medical care enjoyed by workers here to the low level prevailing in most health insurance countries.

A Nazi Joke

It appears that Dr. Schacht visited Montagu Norman, governor of the Bank of England, and requested a loan of £50,000,000.

"What is your security?" asked Mr. Norman.

"Well, underground we have our unexploited iron and coal, and above ground, as a guarantee for this collateral, we have our *Fuehrer*."

"If you could reverse the conditions I might be able to accommodate you," replied the governor of the bank.—Moncton Transcript.



LIFE INSURANCE AS INVESTMENT

By HENRY C. BLACK and
ALLISON E. SKAGGS

EVER since the beginning of time, men in all walks of life have been engaged in a struggle for economic security. Since history began, we have sacrificed something Today that we may have something Tomorrow. Modern man stores money with which to buy goods. His savings are placed in savings banks, building and loan associations, stock exchanges, mortgage loans, real estate, investment trusts, government bonds, and life insurance.

The subject matter in this article is being confined to an analysis of life insurance as an investment. The statement is sometimes made that "life insurance is all right for protection, but isn't a good investment." Occasionally this statement is made by persons otherwise well informed on financial matters. The purpose of this article is to consider the attributes of an ideal investment in its application to the life insurance investment.

Our first consideration is *Safety of Principal*. In this respect there has never been the loss of a single penny to a policy holder by any mutual legal-reserve life insurance company, organized as such. The vast majority of life insurance companies in America today operate under the mutual legal-reserve system.

Our second consideration is *Reasonable Rate of Return*, consistent with dependable safety. In this respect it is found that the rate of return of the life insurance investment has been exceedingly good. Most companies guarantee 3% or 3½% under their contracts. The average rate has been considerably higher due to the payment of excess interest earnings under the mutual principle, over and above the guaranteed rate of return.

Our third consideration is *Regularity and Stability of Income*. The life insurance investment rate is likely to maintain the highest level of interest rates consistent with absolute safety. The life insurance portfolio represents an accumulation of purchases

over a long period of time, thus containing many long-running bonds of high yield, acquired at a favorable time.

Our fourth consideration is the *Avoidance of Managerial Care*. The handling of an investment account involves experience, skill, watchfulness, and power of analysis. Outside of the premium payment, the insured is freed of all managerial care such as investigation, analysis, appraisal, spread of risk, re-investment, and collection of income. Also burdens of a routine nature, responsibility, and worry.

Our fifth consideration is *Non-fluctuation in Value*. The life insurance investment, represented by the cash value of the contract, always remains at the promised amount. Life insurance is a depository institution, based upon the law of averages as it relates to investment. It is rated "A." The uncertainty in the price of a good bond is due, in part, to the certainty of the interest payment. In life insurance there is no fluctuation.

Our sixth consideration is *Proper Spread of Risk and Avoidance of the Dangers of Individual Selection of Investments*. The average investor in bonds, stocks, mortgage loans, etc., is subjected to much inconvenience and expense by way of investigation, collection of dividends, and the payment of minimum commissions. Most investors cannot diversify sufficiently to apply the law of averages. The life insurance portfolio represents the application of averages with respect to sheer number of investments, different economic interests, geographic location, maturity of obligations, and time of purchase. In life insurance there is no individual selection of investments. Any losses suffered are more than counterbalanced by gains in other directions.

Our seventh consideration is *Protection against Claims of Creditors*. Most states exempt life insurance payable to a designated beneficiary against the claims of creditors of the insured. Our eighth consideration is *Ready Marketability at Par*. A good investment has marketability. Life insurance meets this requirement in full, after the surrender-charge period has ex-

pired. In practice, the promised cash values are payable upon demand.

Our ninth consideration is *Suitability for Quick Borrowing*. The cash accumulations on a life insurance policy may be borrowed on without delay or publicity at a guaranteed rate of interest, usually 6%, for the full amount of the cash value. There is no demand for repayment. Compared to other forms of collateral, the margin of safety is exceptionally low.

Our tenth consideration is *Favorable Taxation Treatment*. The owner of a life insurance or annuity policy receives very favorable tax treatment at the hands of both the Federal and State governments, specific federal estate tax exemptions being granted in addition to the general exemptions. Similarly, state inheritance tax laws make similar exemptions available to the holder of life insurance and annuity contracts. It is the only form of property which can be made completely exempted from federal estate and state inheritance taxes by proper arrangement.

Our eleventh consideration is *Favorable Denomination*. Life insurance is issued in convenient units, both as to amount and mode of payment. It meets the situation of convenience for all people.

Our twelfth consideration is *Acceptable Duration*. Investors like investments that run over a considerable period of time. The life insurance investment meets this situation. Contracts ranging from five years to one's age of 96 years may be purchased. Further, once a policy has been purchased and the owner desires to mature the investment earlier, he has access to the cash surrender value.

Our thirteenth consideration is *Possibility of Speculative Gain*. Life insurance is non-speculative from the standpoint of the promised cash value. From the standpoint of a premature death, there is a large appreciation of principal. It is always in favor of the policyholder. In this respect it may be likened to a convertible bond.

Our fourteenth consideration is *Full Title to a Part*. The life insurance investment is not an instalment plan of investment. It is a series of separate, distinct entities, each one complete in itself and conveying 100% title thereto, after full legal

reserve surrender values are granted. Under instalment investments (bonds, stocks, real estate, etc.) this is not true—title does not pass until completion of the purchase-paying period.

Our fifteenth consideration is *Convenience of the Instalment Plan*. Although not constituting an instalment plan of investment in the strict sense, yet in form, life insurance gives all the advantages of an instalment plan of investment. If death interferes in the completion of the instalment plan, it is completed through the application of the decreasing term insurance factor.

Our sixteenth consideration is *Adequate State Supervision and Control*. One of the outstanding sources of investment protection is efficient state supervision and control. Here the life insurance investment stands unexcelled. This supervision and regulation is not limited to the statutes and departmental supervision of the state in which the Company is incorporated or domiciled, but is exercised in every state where the Company writes business. Some legal safeguards are: (1) approval of the wording of contracts; (2) regular state audits of Company books; (3) access to Company books; (4) character of investments strictly controlled; (5) the state determines the method of valuing assets held.

Our seventeenth consideration is *Adequate Publicity*. Adequate information is easily obtainable. The insurance departments require detailed periodic reports; the essential facts are then published. Policyholder's inquiries may be directed to the insurance commissioner of his state. The insurance press and insurance publishing companies give detailed analysis of the financial reports of the companies as they are issued.

Our eighteenth consideration is *Correct Psychology*. Life insurance enables the business and professional man to carry the same without devoting time from his business or profession. It represents the slow, sure, compound interest method of winning a competency, as contrasted to the speculative method.

Our final consideration is its *Adaptability to a Program Meeting Essential Investment Objectives*: namely, family and business reverses, old age income, liquidation emergencies, and postmortem emergencies.

DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

FROM THE PRESIDENT-ELECT

BURTON R. CORBUS, M.D., Grand Rapids
President-Elect, Michigan State Medical Society

Nineteen hundred thirty-eight rapidly draws to a close. It has been a worrisome, threatening year. Happily, the war clouds of Europe seem less sinister. The general social and economic situation in this country at the moment shows distinct signs of improvement.

The year has brought to the profession of the United States a very definite threat of governmental control of the practice of medicine, vague threats in the form of actual plans which would reform (*sic*) the practice of medicine, veiled threats in the form of "if you don't, we will," and some threats not so veiled, as in the unusual and odd attempt to obtain a grand jury indictment of the American Medical Association on charges made public before the indictment was sought. Distinctly the profession has been put on the spot.

The claim is that the present method of the practice of medicine is outworn, yet with all its creaking, the old machine still seems to work pretty well in almost all parts of the country. It must be working reasonably satisfactorily if results may be taken as evidence, for there has never been a time when the mortality and the sick rate figures of this entire country has been so low as in 1938. This is especially true of Michigan and the neighboring state of Illinois.

We doctors recognize that there is a weakness in the distribution of medical care. We recognize that some of the traditional methods and activities of medical practice have become outmoded. We are not averse to change if in this change we can better combat disease, bring a higher degree of health to the people, and find a reasonably satisfactory life for ourselves. We are proud of the fact that in our battle against disease we have made such tremendous strides, and in this battle we have had less help from the government than the farmer has received for the fight against disease in barnyard animals. We would like to see an easier economic approach to the unexpected illness with its hospitalization and medical expenses.

If the reformers will just be a bit patient the profession itself will work out this problem. We have not been unconscious of the needs, and this is especially true of Michigan. Five years ago, we brought out our survey of medical service in Michigan. We had in mind then, as now, the need for certain changes in medical distribution. Our social objectives are just as definite as are the objectives of these altruists and a darn sight more practical. We know the patient's psychology, we know the patient's needs, we are confident that these needs can be supplied without the loss of traditional safeguards and guarantees, and without the elimination of the traditional and essential doctor-patient relationship. Government subsidies, yes, for the impoverished, for the prevention of disease, especially the contagions, for the education of the public in health hygiene in its various aspects, in some instances perhaps for assistance directed to the fur-

ther education of the practicing physician, and of course there must be subsidy for the care of the insane and the feeble-minded. But we hold that it is the right of the patient to choose his own doctor and pay him, and we are convinced that where the doctor is in competition for the favor of the patient, there develops a character and mental growth and skillfulness in his art which enables him to bring his patient the best service.

In 1939, it is likely that the profession will be confronted with the actuality of definite legislative action. Organized medicine is well represented by a committee of seven practicing physicians now serving as a liaison between the Society and government groups. I believe that we can feel confident that in these preliminary meetings this committee will show as much tolerance as the situation demands, as much courage as its obligations to the profession and its patients require when adverse and dangerous ideas are promulgated, and that they will be willing to make concessions where concessions must be made and where they can be made without sacrifice of principle and without sacrifice of those elements which make for self respect, satisfaction in work and happiness without which the individual doctor cannot grow in character and ability, and without which it will be impossible for him to give good service to his patient.

The Michigan profession is not tradition-bound. If there is a better way to practice medicine, we want to practice it that way. While we do not admit that the people of Michigan are suffering from a material lack of medical care, we do feel that there is a need for an improvement in distribution, and we believe that it is possible to work out a plan whereby the financial load incident to unexpected illness can be lightened without lessening the quality of service or interfering with the traditional ideals of medicine. Michigan will continue to exert every effort, through her postgraduate courses, to improve the quality of medicine. In this practical idealism Michigan has ever been among the leaders.

COUNCIL AND COMMITTEE MEETINGS

1. Friday, December 9, 1938—Contact Committee to Governmental Agencies—Owosso City Club, Owosso—6:30 p.m.
2. Sunday, December 18, 1938—Executive Committee of The Council—Hotel Statler, Detroit—12:30 p.m.
3. Saturday, January 7, 1939—Executive Committee of The Council, Hotel Statler, Detroit—6:30 p.m.
4. Wednesday and Thursday, January 18 and 19, 1939—The Council—Hotel Statler, Detroit—10:00 a.m.

EXECUTIVE COMMITTEE OF THE COUNCIL

HIGHLIGHTS:

1. Group Hospital Service and Medical Care Plans studied for presentation to M.S.M.S. House of Delegates.
2. Plans for M.S.M.S. Convention for 1939 approved; extra day (Friday) added.
3. Committees of The Council appointed.
4. T. F. Heavenrich, M.D., resigns as Councilor of 7th District.
5. Requisites for Associate Fellowship in Postgraduate Medical Education, M.S.M.S., widened.
6. Automobile License Plates for physicians, with "M.D." thereon, available in 1940.
7. Possibility of working out agreement with all interested groups re: liens in accident cases discussed.

October 19, 1938

1. *Roll Call.*—The meeting was called to order by Chairman P. R. Urmston at 2:30 p. m. in the Olds Hotel, Lansing, with all members present. Also present: Drs. H. A. Luce, B. R. Corbus, L. Fernald Foster, J. H. Dempster, M. H. Hoffmann, Henry Cook, R. H. Pino, Reuben Maurits, H. W. Pierce, Don W. Gudakunst, Jos. E. Barrett, and Executive Secretary Wm. J. Burns.
 2. *Minutes.*—The minutes of the meeting of The Council, September 20, were read and approved.
 3. *Financial Report.*—The financial report was presented and approved. The bills payable for the month were presented and on motion of Drs. Carstens-Moore were ordered paid. Analysis of actual expenditures for nine months of 1938 vs. Budget estimates was presented and studied.
 4. *County Clerks' Assn. Resolution.*—The Chairman of the Contact Committee to Governmental Agencies, Dr. Cook, introduced Messrs. Stein and Gibbs who presented the resolution of the County Clerks' Assn. re: the pre-nuptial examination law. This was discussed generally by all present, including the Health Commissioner, who stated that no recent complaints had been received by his department relative to the law. It was felt that any necessary changes, which should be made in the future, should be the basis for joint consideration by all interested parties.
 5. *Report from Committee on Distribution of Medical Care.*—Chairman Urmston reported on recent meeting with representatives of hospitals in Detroit on October 12, on the action of certain Hospital executives in Detroit in forming a group hospitalization corporation, and the action of the M.S.M.S. House of Delegates relative to group hospitalization, for presentation to a future special meeting of the M.S.M.S. House of Delegates. General discussion ensued, and resulted in a motion by Drs. Carstens-Greene that the Committee on Distribution of Medical Care be authorized and directed to make a further study, to present concrete plans to the Executive Committee of the Council, with a view to referring same to the House of Delegates, at the earliest possible moment. Carried unanimously.
 6. The Chairman introduced Dr. Joseph E. Barrett, Director, Michigan Hospital Commission, who spoke re: the problems of administering the state hospitals of Michigan.
 7. *Michigan State Nurses' Association.*—A letter from this association was read, relative to the principle of health insurance. The Executive Secretary was authorized to communicate with the Secretary of the Nurses' Association.
 8. *Resignation of Councilor T. F. Heavenrich.*—Dr. Heavenrich's letter was read. Motion of Drs. Carstens-Moore that the letter be referred to President Luce, with a view to making the appointment of his successor, for future reference to the Executive Committee of The Council; and that the M.S.M.S. Secretary draft a letter to Dr. Heavenrich thanking him for his years' of service and counsel to the Michigan State Medical Society. Carried unanimously.
 9. *Committee Reports:*
 - (a) The Joint Committee on Health Education, presented by Dr. Corbus: radio programs begin as of Nov. 1, 1938. Dr. Corbus presented the problem of talks on mental hygiene, which was discussed by Dr. Hoffmann. Dr. Corbus also presented the desirability of having the chairmen of various committees (Cancer, Maternal Health, Mental Hygiene, Radio, and Preventive Medicine) meet with the Joint Committee on Health Education, and with the Extension Division of the U. of M., to discuss talks before lay groups and radio talks, the expenses of meeting attendance to be borne by the Joint Committee. This was approved by the Executive Committee of The Council.
 - (b) Contact Committee to Governmental Agencies: Dr. Cook reported on the complaint that the physicians of Wexford County were being requested to help defray the expenses of employing a clerk to check welfare vouchers—this is being investigated. Dr. Cook also reported on the possibility of working out an agreement with the insurance companies and the hospitals re: liens in accident cases; Dr. Cook's committee was authorized to proceed with this endeavor.
 - (c) Medico-Legal Committee's monthly report was presented; also the monthly report of the Maternal Health Committee, the Occupational Disease Committee, the Iodized Salt Committee, Advisory Committee on T.B. Control, Advisory Committee to Woman's Auxiliary, Mental Hygiene Committee and the Legislative Committee.
- The Membership Committee report was approved, including authorization to reimburse the chairman \$25 for expenses incidental to stenographic work in 1937-38.
- Special stationery to be printed for individual committees, was discussed, and motion made by Dr. Carstens-Greene that no special stationery be printed for individual committees, without the approval of the Executive Committee of The Council. Carried unanimously.
- The suggestion of the Chairman of the Postgraduate Medical Education Committee, that the chairmen of the Preventive Medicine Committee, Cancer Committee, Radio Committee,

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Maternal Health Committee, Mental Hygiene Committee, and Joint Committee on Health Education be made members ex-officio of the P. G. Medical Education Committee, as per supplemental report of the P. G. Medical Education Committee for 1937-38, was discussed. The Executive Committee instructed the Secretary to inform Dr. Bruce of an action that will satisfy his needs re: chairmen of these different committees attending meetings of the Committee on P. G. Medical Education.

The Chairman of the Committee on P. G. Medical Education referred for consideration the addition of two items to the requisites for certification for Associate Fellowship in P. G. Medical Education, M.S.M.S., these were discussed, and finally adopted as follows:

"11. Membership and regular attendance on accredited hospital staff conferences.....

2-10 units

"12. Awarding of Fellowships in P. G. Education to members of the Michigan State Medical Society on the basis of research and teaching activities of the Michigan Postgraduate Program; the first of such awards to be made in 1939."

Motion of Drs. Moore-Greene that the Executive Committee approve the addition of the two items as above listed, to the requisites for certification. Carried unanimously.

10. *Plans for 1939 Convention in Grand Rapids.*—Secretary Foster outlined the plans, including the same type of program as was successful in 1938, and extending the General Assemblies to include Friday, with an economic talk on Thursday evening; the technical exhibit to be arranged according to the labyrinth idea; the dates to be Sept. 18 to 22, 1939.

Motion of Drs. Brunk-Carstens that the above plans, based on the 1938 experience of general assemblies (except for Wednesday morning) be approved. Carried unanimously.

11. *State Constitutional Amendment No. 3.*—This was discussed, and on motion of Drs. Riley-Brunk, the principle of restricting appropriations, as was exemplified in Amendment No. 3, was approved.
12. *Welfare Reorganization.*—A letter from the W.C.M.S., enclosing a discussion of the welfare reorganization bill, with the recommendation that same be forwarded in turn to all of the county medical societies in Michigan, was presented and discussed. The Executive Committee of The Council was agreeable that the W.C.M.S. send out these statements to the various county medical societies of Michigan, and instructed that the secretary so notify the W.C.M.S.
13. *Upper Peninsula Medical Society Meeting.*—Plans for this meeting, being arranged by Dr. Foster and Mr. Burns at the request of the President of the U. P. Medical Society, were discussed.
14. *Automobile insignia for Physicians.*—Possibility of automobile licenses with "M.D." thereon for doctors of medicine, was discussed. Motion of Drs. Moore-Greene that the Executive Secretary be authorized to contact the Secretary of State relative to the possibility of such insignia for 1940 and subsequent years. Carried unanimously. Membership cards for M.S.M.S. members was approved by the Executive Committee, beginning with 1939, as an aid to registration at the annual meeting.
15. *Crippled Children Commission's Fee Schedule.*—These schedules, to be promulgated as of Sept. 1, 1938, were discussed. The secretary was instructed to send a letter to the C.C.C.

and to the Auditor General, from the Executive Committee of The Council of the State Society, inquiring as to why these schedules were so delayed.

16. *Accident Insurance.*—The Executive Secretary was instructed to investigate the cost of accident insurance on Secretary Foster and Executive Secretary Burns, payable to the M.S.M.S.
17. *Reprints of Constitution and By-Laws.*—The Executive Committee authorized the reprinting of 300 copies of the Constitution and By-Laws of the M.S.M.S. for distribution to M.S.M.S. officers and the Presidents and Secretaries of county medical societies.
18. *American Medical Women's Association.*—Secretary Foster reported on the recent meeting of the Michigan Branch of this Association, and the misunderstanding resulting from the election.
19. *Adjournment.*—The meeting was adjourned at 8:15 p.m.

November 16, 1938, Meeting

1. *Roll Call.*—The meeting was called to order by Chairman P. R. Urmston at 3:30 p.m. in Statler Hotel, Detroit, with all members present; also Drs. Henry A. Luce, L. Fernald Foster, J. H. Dempster, Wm. A. Hyland, M. H. Hoffmann, G. C. Penberthy, R. H. Pino, and Executive Secretary Wm. J. Burns.
2. *Minutes.*—The minutes of the meeting of October 19 were approved as printed.
3. *Financial Report.*—The report was accepted and bills payable were approved and ordered paid, motion of Drs. Carstens-Brunk.
4. *Council Committees.*—The Committees as submitted by Chairman Urmston were approved, as follows:
 - Finance Committee:
 - H. R. Carstens, Chairman
 - V. M. Moore
 - H. H. Cummings
 - W. E. Barstow
 - T. E. DeGurse
 - County Societies Committee:
 - I. W. Greene, Chairman
 - Wilfrid Haughey
 - C. D. Hart
 - W. H. Huron
 - E. F. Sladek
 - Publications Committee:
 - A. S. Brunk, Chairman
 - J. E. McIntyre
 - F. T. Andrews
 - Roy H. Holmes
 - Geo. A. Sherman
5. *Date of County Secretaries' Conference* was left to the decision of the Council Chairman, Secretary, and Chairman of the Legislative Committee (set for January 15, 1939).
6. *Committee Reports were presented*, as follows:
 - (a) Maternal Health
 - (b) Health League
 - (c) Contact Committee to Governmental Agencies
 - (d) Occupational Disease
 - (e) Preventive Medicine
 - (f) Medico-Legal Committee
 - (g) Joint Committee
 - (h) Radio
 - (i) Mental Hygiene
7. *Treasurer's Report* was accepted.
8. *"Brochure on Burns"* was presented by Dr. G. C. Penberthy and approved, motion of Drs. Carstens-Brunk.
9. *1939 Annual Meeting Plans* were presented. Leases were ordered signed, motion of Drs. Carstens-Brunk.

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10. *Additional Committee Appointments* as made by President Luce were approved on motion of Drs. Carstens-Riley.
11. *Expenses of Dr. R. G. Tuck* for Health League were ordered paid, motion of Drs. Greene-Carstens.
12. *Notification to all committee chairmen*, re: clearing of all meetings through the Executive Office and notices to be sent by Executive Office was to be made by the Secretary, motion of Drs. Carstens-Moore.
13. *Auto Emblems, M.D.*, were announced as available from Secretary of State in 1940.
14. *Vote of Thanks* was accorded Captain L. A. Potter for his activity in limiting cult practices, motion of Drs. Brunk-Greene.
15. *An editorial on Election Results* presented by Editor Dempster was referred to Drs. Luce, Corbus and Brunk for editing and approval, motion of Drs. Moore-Carstens.
16. *Wayne County Supplement and the Pneumonia Brochure* were ordered distributed to the County Secretaries at the January Conference, motion of Drs. Greene-Riley.
17. *The Need for a New Medical Practice Act* was discussed, and ordered referred to the Legislative Committee, motion of Drs. Moore-Brunk.

Recess for Dinner at 6:00 P.M.

Reconvened at 8:00 P.M.

18. *Committee on Distribution of Medical Care* reported on Group Hospitalization and Medical Care Plans:
 - (a) Enabling Act
 - (b) By-Laws
 The set-up was ordered referred to an expert insurance man, the Insurance Commissioner and the Committee on Distribution of Medical Care for re-draft and reference back to the Executive Committee, motion of Drs. Moore-Brunk. A vote of thanks was accorded the Committee on Distribution of Medical Care for their fine work, motion of Drs. Carstens-Moore.
19. *Adjournment* at 11:00 p.m.

Minutes of Meeting of Officers and Committee Chairmen of the Michigan State Medical Society with Doctor Corbus, Chairman of the Joint Committee on Health Education, and Doctor Fisher of the University Extension Division, Detroit, Monday, November 26, Noon

Present: Doctors R. C. Moeblich, representative Joint Committee; L. O. Geib, Preventive Medicine; Henry Luce; G. C. Penberthy, Radio; H. R. Carstens; A. L. Brunk; B. W. Carey, Children's Fund; A. B. McGraw, Cancer; C. A. Fisher; J. H. Dempster; B. R. Corbus.

The chairman stated that his purpose in calling this meeting was to develop a closer liaison between the officers of the State Medical Society, certain of its committees, and the Joint Committee, for the purpose of increasing the utilization of the facilities of the Joint Committee in presenting health education to the laity. He stated that the Joint Committee has ever been insistent that there shall be an authoritative basis for the material presented in health talks. It would seem that the responsibility for the presentation of this material should rest very definitely upon the various committees of the State Society.

The Joint Committee, through its affiliation with Doctor Fisher and the Extension Service of the University, has the machinery and offers a very special opportunity for the dissemination of health information.

The Committee is prepared to materially expand the activities of its Speakers' Bureau, and asks the cooperation of this group.

In the discussion which followed the following subjects and reports were considered:

1. The function of the various committees in re:
 - a. The selection of the personnel which should be based on geographical convenience as well as on the ability of the speaker to present his subject. The names of these speakers should be sent to Doctor Fisher for listing, or the Committee Chairman should be prepared to furnish the speaker on request of Doctor Fisher.
 - b. The group suggests that the Committees—Cancer, Mental Hygiene, Maternal Welfare, etc.—each prepare a series of talks, or outline of talks, to be placed on file in Doctor Fisher's office, to be sent to the proposed speaker, on which he might base his talk. (This plan was inaugurated by the State Dental Society and has proven most successful.)
2. A report by Doctor Corbus on the work of the Joint Committee last year.
3. A report by Doctor Fisher on the work of the Joint Committee so far this year, including lectures to lay groups and radio talks.
4. A report by Doctor Penberthy supplemented by Doctor Fisher, on the activities of the Radio Committee. Script for radio talks are sent out two weeks in advance. The broad-casting stations are coöperating satisfactorily and are apparently well satisfied with the excellent material Doctor Penberthy's committee has provided.
5. A discussion by Doctor McGraw concerning methods and technics to be used by the Cancer Committee in getting information, first to the public, and second, to physicians.
6. A discussion of the possibility of having the State Medical Society and Joint Committee sponsor classes in public speaking. It was suggested that the Joint Committee might help in the organization of such classes and both directly and indirectly help to make the project possible. The State Society has recognized the need for such instruction and is now bringing the matter before County Societies.

HOUGHTON-BARAGA-KEWEEANAW

The December meeting of the Houghton County Medical Society was the occasion of a very enjoyable social gathering. Thirty-two persons, members and wives, sat down at 7 P. M. to a steak dinner, served at the Miscowaubik Club, Calumet, honoring the guest of the evening, Dr. S. G. Higgins, of Milwaukee. Dr. Higgins, who spent some time as a visiting ophthalmologist to various missions and communities in India, gave a very interesting talk on customs and dress in India, the conditions under which his work was done, and some insight into the social and economic conditions involved. His talk was illustrated by colored lantern slide views, and moving pictures of the people, their homes, and customs.

Dr. Higgins' collection of articles of dress and jewelry in native silver, proved very interesting, especially to the ladies. Beautiful Kashmir shawls, native saris, and hand-wrought silver bracelets and rings, were displayed.

While the doctors engaged in a short business session, opportunity was afforded for the subject of a medical auxiliary to be discussed by the ladies. Much interest was shown, and it was decided to hold a meeting for purposes of organization, on the evening of the next medical meeting.

C. A. COOPER, M.D., Sec.

JOUR. M.S.M.S.

WOMAN'S AUXILIARY

President—Mrs. P. R. Urmston, 1862 McKinley Avenue, Bay City, Michigan
Sec.-Treas.—Mrs. R. E. Scrafford, 2210 McKinley Ave., Bay City, Michigan
Press—Mrs. J. W. Page, 119 N. Wisner Street, Jackson, Michigan

THE month of November brought two Mid-winter Board meetings, that of the national Auxiliary, in Chicago, where Michigan was represented by Mrs. Urmston and Mrs. Scrafford, and the State Board meeting in Detroit which followed that of the National Board. The reports of these two meetings follow. These reports should be of interest to every member since it is through such meetings that our Auxiliary receives its sense of direction, determines its objectives and feels the inspiration that comes from joining with women throughout the country for a common purpose.

Mid-year Meeting of the National Board

The National Board meeting of the Woman's Auxiliary to the A.M.A. was held at the Palmer House in Chicago, November 11, 1938, at 10:00 A. M., and was called to order by the President, Mrs. Tomlinson. Thirty-two answered roll call.

Five past presidents and three directors were present, also Mrs. Samuel Clark Red, who conceived the idea of a national Auxiliary.

In Mrs. Tomlinson's address she stressed organization, spoke of the stability and growth of the auxiliary and complimented us all on our coöperation and enthusiasm.

Mrs. Rollo K. Packard, Chicago, president-elect, spoke briefly but gave no report. Then followed the report of the first vice-president, Mrs. Frank N. Haggard, of San Antonio, Texas, Organization chairman.

May I explain at this point that the vice-president's committee is composed of the 2nd, 3rd and 4th vice-presidents, located in strategic points, thereby covering the entire field of activities.

Mrs. Haggard spoke of the importance of personal contacts, lack of interest in medical societies in some unorganized states, of difficulties, particularly in the Western states, because of the great distances to travel.

As Historian, Mrs. A. E. Barnes of Texas reported her work of completing data on outstanding activities of the Auxiliary from 1934 to 1939, to be added to the Pamphlet entitled "The First Twelve Years"—1922 to 1934. It was decided to have a committee check, word by word, this addition as there were many discrepancies in the recording of the original pamphlet.

The meeting adjourned for luncheon. The guest speaker, Dr. Wright, chairman of the Advisory Council and a Trustee of the A.M.A., was unable to be present, detained at an important meeting. In his place, Dr. Bauer, A.M.A., gave the address, assuring us that in promoting *Hygeia* we are in no sense book agents, but giving to the public information obtainable in no other magazine and so necessary at this time.

He also urged us to be members of as many lay organizations as possible and to present authentic information on Socialized Medicine. A most instructive address.

The meeting continued at 2:00 P. M.

Report of special committee on membership awards was given by Mrs. Herbert Henkel, Illinois. She asked for advice from the Board to determine upon what basis this award was to be given. It was finally decided to be on a percentage basis.

There was much discussion as to awards, and a motion was made and carried that no awards in the

future could be given without the consent of the president and Board members.

Mrs. Lester, *Hygeia* chairman, reported her goal for this year was 15,000 subscriptions.

She asked Mrs. Herbert, also of Tennessee, to explain how they were able to place 6,182 subscriptions of eight months in Tennessee. Mrs. Herbert said a Bill supported by the Public Health Commissioner and the Commissioner of Education was passed by the legislature. Through this bill they were able to place *Hygeia* in every school in Tennessee.

The state presidents' reports followed. Outstanding were Utah, Pennsylvania, New York, Missouri and Texas.

Dr. Wright addressed us just before adjournment. He said his message had been given by Dr. Bauer, but he wished to assure us of his coöperation. He emphasized the thought that each state has its own problem and wished us every success.

A very successful meeting adjourned at 6:00 P. M.

Respectfully submitted,

MRS. P. R. URMSTON, President

Mid-year Meeting of the State Board

The Mid-year Board Meeting of the Woman's Auxiliary of the Michigan State Medical Society was held at the Woman's City Club, Detroit, Michigan, November 18, 1938.

The meeting was called to order at 2:00 P. M. by the president, Mrs. P. R. Urmston.

The following answered roll call: Officers and chairmen: Mrs. Urmston, Mrs. Christian, Mrs. Walker, Mrs. Scrafford, Mrs. Hicks, Mrs. Collisi, Mrs. Page, Mrs. Andrews, Mrs. Bond, Mrs. Whitney. County presidents: Mrs. Scrafford, Mrs. Wenke, Mrs. Alter, Mrs. Butler, Mrs. Bond, Mrs. Sutton, Mrs. Geib.

The president, Mrs. Urmston, read her report of the National Board meeting held in Chicago, November 11, which was approved.

The minutes of the pre-convention and post-convention meetings were read and approved.

The Treasurer's report showed a balance of \$211.09 and was approved. Reports of the Standing Committees followed. Mrs. Jaenichen's report was read by Mrs. Harvey. Reports were also given by Mrs. Collisi, Mrs. Walker, Mrs. Page, Mrs. Andrews and Mrs. Bond. Mrs. Butler reported on exhibits.

There was no unfinished business. New business was in order.

Mrs. Urmston reported a communication from Dr. Foster to the effect that the State Medical Society felt that, owing to our growth as an Auxiliary, we should finance all of our activities. He also suggested badges for all members for the State Convention. Mrs. Urmston then proposed, due to these suggestions, we discuss a plan for a budget of our expenses. Mrs. Walker moved, seconded by Mrs. Geib, to appoint a committee of five, headed by the president and treasurer, to budget expenses. Motion carried.

Mrs. Andrews moved, seconded by Mrs. Christian, to leave the purchase of badges to the Budget Committee. Motion carried.

Mrs. Geib moved, seconded by Mrs. Collisi, that only president-elect be sent, with expenses paid, to

WOMAN'S AUXILIARY

the national convention. This motion was discussed and finally amended by Mrs. Whitney, seconded by Mrs. Hicks, that both the president and president-elect be sent to the national convention whenever finances permitted. Motion carried as amended.

The President then appointed the Budget Committee—Mrs. Whitney, chairman, assisted by Mrs. Hicks and Mrs. Page—their conclusions to be sent to the president and treasurer for their approval.

As there was no further business, Mrs. Sutton moved, seconded by Mrs. Andrews, that the meeting be adjourned. Motion carried.

Respectfully submitted,
MRS. R. E. SCRAFFORD, *Secretary*

Bay County

The Auxiliary to the Bay County Medical Society held its first meeting of the year on October 12, at the Bay City Country Club. Twenty-six members who were present were served an enjoyable buffet supper. This was followed by a business meeting. Outstanding among topics discussed were plans for a rummage sale to be held in the near future. Money was needed to "carry on," for the treasury was getting that "lean and hungry look."

Within a few days following the meeting, the committee placed in charge of the rummage sale had made arrangements with a local merchant to use a vacant store building, rent free, on October 20 and 21. Considering the fact that we had never sponsored such a venture before, the response of all members in contributing and collecting material was very fine. As a result, our treasury is bulging with the seventy-five dollars netted as a profit.

At the November meeting, held on November 9, at the home of Mrs. M. R. Slattery, Mr. William J. Burns, Executive Secretary of the Michigan State Medical Society, outlined current proposals before American and Michigan Medical Societies, particularly the five major recommendations made by the investigating committee headed by Josephine Roche at Washington, D. C., in July. He analyzed the significance, strength and weakness of each proposal, suggesting changes which might make them more effective. The address was most helpful in building up a comprehension of the problems of the medical profession and an intelligent understanding of these problems.

MRS. LYNN J. STINSON,
Corresponding Secretary

Kalamazoo County

Mrs. Kenneth Crawford entertained the Woman's Auxiliary to the Academy of Medicine on November 15, at a coöperative dinner, thirty-six members attending.

Mrs. W. W. Lang gave an interesting report of the State meeting held in Detroit.

Following the business meeting, the group enjoyed a review of Margaret Halsey's book, "With Malice Toward Some," which was ably presented by Mrs. Gerald Rigtink.

Members brought a shower of jams and jellies to be distributed in Community Christmas baskets.

(MRS. HUGO) BARBARA AACH,
Press Chairman

Kent County Woman's Auxiliary

With 158 members, the largest number ever to have affiliated, Kent County Auxiliary is enjoying a most successful year. Meetings have proved extremely interesting and the wide variety of entertainment is found to be a great drawing card for membership and attendance.

In addition to the delightful talk given by Mrs.

P. L. Thompson, an auxiliary member, on her recent round the world voyage, our November meeting honored our past presidents: Mrs. Thomas C. Irwin, Mrs. Burton R. Corbus, Mrs. A. Verne Wenger, Mrs. Henry J. Pyle, Mrs. Robert H. Denham and Mrs. Carl F. Snapp, who all spoke briefly and entertainingly on various occurrences taking place during their particular regime.

The December program will also be conducted by members and will feature the play reading of "On Borrowed Time" under the direction of Mrs. Ralph L. Fitts.

All standing committees are functioning excellently, and among achievements recently accomplished is the placing of 172 six month subscriptions of *Hygeia* in the county rural schools and the beginning of a collection of printed articles pertaining to medical legislation.

JANE R. FRANTZ,
Press Chairman

Jackson County

The November meeting of the Women's Auxiliary was a social one, Mrs. W. E. McGarvey, of the social committee, being chairman. The members met at the home of Mrs. T. E. Schmidt, and were served a 6:30 dinner. The committee in charge of the dinner was composed of the following members: Mesdames C. D. Munro, chairman, R. M. Cooley, W. W. Lathrop, R. J. Hanna, and M. J. McLaughlin.

Mrs. R. H. Alter, president, conducted a business meeting, at which time suggestions for a project for this year were talked over and placed in the hands of the project committee. Reports of the secretary and treasurer were also read at this time.

The remainder of the evening was spent in playing bridge, the prizes being won by Mesdames Shaeffer and Porter.

ANNA HYDE SHAEFFER,
Press Chairman

Saginaw County

Mrs. Robert Jeanichen was hostess to forty members of the Saginaw County Medical Auxiliary, Tuesday evening, November 15.

During a short business meeting it was decided to place *Hygeia* in twenty rural schools.

Mrs. William English, Legislative chairman, gave a comprehensive résumé of the present trend toward "socializing medicine."

Mrs. Aaron C. Button was winner of the door prize drawn during the social hour. Refreshments were served by a committee of which Mrs. Henry J. Meyer was chairman.

MRS. MILTON G. BUTLER,
Press Representative

Washtenaw County

The newly organized Washtenaw County Medical Society Auxiliary held its second dinner meeting on November 8, at the Michigan Union. Dr. Claire E. Straith, a sponsor of the local auxiliary, and Mrs. Straith of Detroit were honor guests.

After a short business meeting, Mrs. Straith, a former president of the Wayne County Medical Society Auxiliary, told of the present projects and accomplishments of that group.

Later the County Medical Society joined the ladies in hearing Dr. Straith's splendid talk on plastic surgery.

A Christmas tea at the home of Mrs. R. Bishop Canfield on December 13, and a joint society dinner dance in February are included in the winter plans by the Auxiliary.

(MRS. C. HOWARD) CECELIA GRAHAM ROSS,
Press Chairman

JOUR. M.S.M.S.

**MICHIGAN'S DEPARTMENT
OF HEALTH**

DON W. GUDAKUNST, M.D., Commissioner
LANSING, MICHIGAN

PUBLIC HEALTH CONFERENCE

The Eighteenth Annual Michigan Public Health Conference, held November 9, 10, and 11 at Grand Rapids, attracted an attendance of well over 1,200 members of the health professions and interested lay persons. The official registration of 991 persons included 50 health officers, 69 physicians, 50 dentists and dental hygienists, 449 public health nurses, 65 sanitarians, 148 lay members of county health committees, 22 laboratories, 14 out-of-state visitors and 124 representatives of miscellaneous professions.

The conference opened Wednesday afternoon with an address of welcome by Dr. Don W. Gudakunst, state health commissioner. Dr. Carleton Dean, of Charlevoix, president of the Michigan Public Health Association, presided at the session. G. Robert Koopman, assistant superintendent, State Department of Public Instruction, the first of the principal speakers, outlined the scope and objectives of the revitalized emphasis upon health instruction in the schools which has become a fundamental philosophy underlying the Michigan Curriculum Program. "The present plan," he said, "consists briefly of making a direct attack upon the problem in close coöperation with the State Department of Health and with the direct support of the social agencies, professional agencies, and foundations interested in health education. The prospects of considerable success seem brighter than at any previous time."

Miss Naomi Deutsch, director of public health nursing, Federal Children's Bureau, termed the current national maternal and child health program "the American adventure in neighborliness." "There are approximately 12,500 maternal deaths in the United States each year, of which one-half to two-thirds might be prevented if facilities for adequate medical care could be everywhere available." "The plan for a national health program to offer more adequate health protection and medical care, shaped by the experiences now being built up to extend and strengthen health programs should bring assured returns in economic stability, in national well-being, and in individual contentment throughout our country," Miss Deutsch concluded.

Discussing "The Role of Government in the Provision of Medical Care," Dr. Gudakunst pointed out that government's rôle is not the practice of medicine, but rather to provide *for* medical care. "Socialized medicine, such as developed in many parts of the world, has no place in our scheme of things in this country." "State departments of health," the commissioner continued, "in fact, all health agencies, have become concerned with this question of government providing for medical care. Health workers are, of course, concerned. They have traditionally, and for many, many years, been concerned with those factors contributing to the death rate, with environmental sanitation and with the spread of communicable diseases, but there is little satisfaction when you keep people alive from one cause and see them die from another cause. Therefore, it is quite logical that health workers have concerned themselves with this problem. Not that they have had hope at any time of putting over a program where they, themselves, would be engaged in the practice of medicine, but we do hope that they can undertake some leadership, on a national and state-wide basis and in their own local

communities, in bringing together the various forces that are existing in those communities so that more and adequate service can be administered. * * *

"Government is concerned, therefore, mainly with the payment for services that the physician has to render—not so much concerned with the quality. Of course, interested; of course, very much concerned in one way, but not concerned to the point where government can say, 'We,' or as more frequently happens, 'I am able to practice medicine much better than anyone else.' That is not government's concern. It is government's concern to make available the money for the payment of services which the physician has to render. Any relationships that are worked out must be on an equitable and satisfactory basis, satisfactory to the medical profession itself. There must be reasonable pay for services. We cannot continue, as we have in many places in some of the feeble attempts to meet this problem, to pay the physician at a very small fraction of what his services are worth. When we do that we quickly prostitute the practice of medicine. When an office service is paid for at the rate of fifteen cents, the patient gets fifteen cents worth of service; and obstetrical service cannot be rendered for the payment of a few dollars. The relationships that are worked out for the payment of these services must be equitable and reasonable for the physician."

Dr. Carl E. Buck, field director of the American Public Health Association, speaking on "Organizing Your Community Resources for Health," urged the directors of every local health department to secure the appointment of a public health committee by the local medical society. "Most of the difficulties that occasionally arise between the public health group and the organized medical profession would be avoided if we had a close liaison between the public health department and the public health committee of each local medical society," he declared.

Dr. William S. Sadler, director and chief psychiatrist of the Chicago Institute of Research and Diagnosis, addressed the enthusiastic Wednesday evening session on the subject of "Mental Hygiene." Psychiatry today," he declared, "is something more than medical psychology. True, it started that way, but today psychiatry is what I prefer to call 'Personology.' * * * It is the person we are dealing with—more and more it is the whole person. Sooner or later some university will establish courses and will grant degrees of D.P.—Doctor of Personology. They will be men and women trained to look at the whole functioning human being in his social situation, with his economic difficulties, with his family obligations, with his personality and individual peculiarities. Until such time as we do have doctors of personology, I believe that the physician—the medical men as a whole under the leadership of psychiatrists—must see to the leadership of the mental hygiene movement. And we want, increasingly, to feel that the public health workers of North America are with us, that they understand the objectives and aims of psychiatry as a highly specialized medical discipline, and mental hygiene as the lay movement symbolizing and focalizing the mental hygiene consciousness of the public at large."

Dr. Henry A. Luce, president of the Michigan State Medical Society and assistant professor of neurology and psychiatry at Wayne University, presided at this session and introduced Dr. Sadler.

"In every local area in Michigan there should be a whole-time health service—either on a city, county or district basis, manned by personnel trained and experienced in the art of health preservation," declared Dr. Henry F. Vaughan, Detroit health commissioner, who addressed the annual dinner meeting. "There exists in the medical and dental pro-

MICHIGAN'S DEPARTMENT OF HEALTH

fessions a latent desire and ability to serve the public in health which must be activated and integrated into programs of community health service, both on a local basis and effectively interwoven with a state-wide health program."

Speaking on "Recent Progress in the National Campaign for the Control of Syphilis," Assistant Surgeon General R. A. Vonderlehr declared that 27 states now have a separate division or section of venereal disease control, and that 29 states have a full-time venereal disease control officer. He commended Michigan's plan for the free distribution of drugs for the treatment of syphilis and the provision of free laboratory diagnostic tests for syphilis for all persons. Eight other states besides Michigan have recently enacted laws requiring a serodiagnostic test for syphilis of applicants for marriage licenses, and three states, including New York, New Jersey and Rhode Island, have laws providing for the discovery and treatment of syphilis in pregnant women, Dr. Vonderlehr reported.

Dr. Burton R. Corbus, president-elect of the Michigan State Medical Society, presided at the Thursday afternoon session. Dr. J. Orton Goodsell, president of the Michigan State Dental Society, also spoke at this session on "The Contribution of Oral Surgery to Public Health."

Dr. Gordon B. Myers, professor of medicine at Wayne University College of Medicine, discussed the use of antipneumococcic serums in Michigan's pneumonia control program. The Michigan Department of Health is now supplying sera to physicians for the treatment of Types I and II pneumonia cases. Dr. Allan J. McLaughlin, of the University of Michigan, outlined a basic program of sanitation, which, he said, must be built upon sound local foundations to succeed in state and nation. Advances in the production and use of pertussis vaccine were discussed by Dr. Pearl Kendrick, associate director of Michigan Department of Health Laboratories. The epidemiology of the recent Shiga dysentery outbreak in Shiawassee county was explained by Dr. Berneta Block, staff physician of the Michigan Department of Health.

At the annual luncheon business meeting of the Michigan Public Health Association, Dr. John L. Lavan, Grand Rapids health officer, was elected president of the association. Other officers include Dr. M. R. Kinde of the W. K. Kellogg Foundation, Battle Creek, vice president; Miss Marjorie Delavan, director, Bureau of Education, Michigan Department of Health, secretary-treasurer; and Dr. Don W. Gudakunst, state health commissioner, representative on the governing council of the American Public Health Association. Dr. Kenneth R. Gibson of Detroit was elected to fill the vacancy on the board of directors. The association voted to hold its next annual meeting in Lansing. Resolutions were adopted honoring the memory of Dr. Richard M. Olin, former commissioner of the Michigan Department of Health, and Dr. U. G. Rickert, president of the State Council of Health, both of whom died during October.

REGIONAL CONFERENCES OF HEALTH DEPARTMENTS

Regional conferences of local health departments are being arranged by the Michigan Department of Health in cooperation with the full time health officers for the purpose of correlating the activities and improving the services of the state and local health departments. The conferences will be held once every two months in each of the various districts which have been organized on a regional basis.

The first of the conferences was held December 7 at Big Rapids with Dr. M. C. Igloe, director of

the Mecosta-Osceola Health Department, as host. The counties represented at this conference included Mecosta, Osceola, Clare, Gladwin, Arenac, Isabella, Midland and Bay. All staff members of these local health departments were invited to participate. Discussion topics and leaders were as follows: venereal disease, Dr. R. S. Dixon; tuberculosis, Dr. A. W. Newitt; pneumonia, Dr. A. B. Mitchell; and administrative problems, Dr. Don W. Gudakunst.

The Northern Michigan Regional Health Conference was held December 14 with health department staffs from Kalkaska, Crawford, Missaukee, Roscommon, Wexford, Alcona, Iosco, Oscoda, Ogemaw, Alpena, Cheboygan, Montmorency, Presque Isle, Antrim, Charlevoix, Emmet and Otsego counties participating. A conference of the Western Michigan departments, including Manistee, Mason, Lake, Oceana, Newaygo, Muskegon, Ottawa and Kent counties, has been scheduled for December 21. Conferences are also being arranged for the Upper Peninsula departments, the Eastern Michigan District and the Southeastern Michigan District.

STATE COUNCIL OF HEALTH MEETS

Dr. Robert B. Harkness, director of the Barry County Health Department, was elected president of the State Council of Health at its advisory session with the state health commissioner in Lansing, November 23. Dr. Harkness succeeds Dr. U. G. Rickert of Ann Arbor, who died October 22. Dr. P. C. Lowery of Detroit, former president of the Michigan State Dental Society and vice president of the American Dental Association, has been appointed a member of the Council to serve the unexpired term of Dr. Rickert, which ends June 30, 1941. Members of the Council discussed proposed changes in the department's rules and regulations for the control of communicable diseases. Further consideration of this subject will be undertaken at a Council meeting scheduled for December 13.

DR. BUCK TO REPORT SOON

A series of preliminary reports to selected groups, based on a survey of Michigan's state and local health services and needs, is being made by Dr. Carl E. Buck, field director of the American Public Health Association, who has been conducting the survey during the past six months. Dr. Buck's final report is nearing completion and will be made public in the near future. Copies of the report and the recommendations of the survey committee will be made available to the officers of the Michigan State Medical Society.

THE FIRST YEAR OF THE PREMARITAL EXAMINATION LAW

Discussing the first year's experience under the 1937 Antenuptial Physical Examination Act before the annual Public Health Conference at Grand Rapids, Dr. W. J. V. Deacon, director of the Bureau of Records and Statistics, reported a decrease of 44 per cent in marriages during the early months of operation of the new law.

"It was to be expected that marriages would decline in number during the early months of operation of this act before the public became fully informed of its purposes and the details of its administration. During the first nine months of 1938 while the marriage law was in operation, the Michigan Department of Health received reports of 20,681 marriages. This compares with reports of 37,242 marriages during the corresponding nine months of 1937 previous to the operation of the

(Continued on page 70)

IN DEPRESSIVE STATES

In depressive states, the suitability of 'Benzedrine Sulfate' (amphetamine sulfate, S.K.F.), as well as its correct dosage, must be determined for the individual patient.

Tentative classifications, however, suggest that 'Benzedrine Sulfate' is most likely to be of use in conditions characterized by diminution of capacity for activity, and that it is apt to be contraindicated in anxiety states accompanied by agitation. In depressive psychopathic states the patient should be institutionalized during the administration of 'Benzedrine Sulfate'.

Initial dosage should be small, ranging from a minimum of 2.5 mg. ($\frac{1}{4}$ tablet) to 5 mg. ($\frac{1}{2}$ tablet). These should be regarded as test doses, and if no effect is obtained from the smallest amount given, the dosage may be progressively increased until a definite effect manifests itself. Usually it is unnecessary to give more than 10 mg. at a single dose. Careful medical supervision during this test period is particularly desirable.

When the correct dosage has been determined, it may be given two or three times a day, bearing in mind that administration in the late afternoon or evening may interfere with sleep. When divided doses are required, the specially grooved tablet may be broken and one-half or one-quarter tablet given.

The effects of 'Benzedrine Sulfate', whether desirable or undesirable, are usually apparent with the first few doses. If there are undesirable effects 'Benzedrine Sulfate' obviously should be discontinued.

BENZEDRINE SULFATE TABLETS



Each 'Benzedrine Sulfate Tablet' contains amphetamine sulfate, 10 mg. (approximately $\frac{1}{8}$ gr.)

The Council on Pharmacy and Chemistry of the A. M. A. has adopted amphetamine as the descriptive name for α -methylphenethylamine, the substance formerly known as benzyl methyl carbinamine. 'Benzedrine' is S.K.F.'s trademark for their brand of amphetamine.

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

Established 1841

CORRESPONDENCE

law. The 1938 figures do not include the final returns from a few counties, but these returns would not significantly change the comparative figures.

"To what extent this has been a loss is, of course, a matter for debate. Economic and social factors other than the new marriage law have a direct reaction upon the marriage rate and must be considered in explaining the decline in the early months of 1938. To what extent this decline means fewer marriages of Michigan residents is a question, since it is true, no doubt, that many persons have gone to other states to be married. I have been glad to notice the reaction to this practice in some cases, however, as persons seem to lay themselves open to the criticism that they went out of the state to be married because they were afraid to take the physical examination. It is also encouraging to note that marriages appear to be increasing in the later months of the year, indicating greater acceptance of the safeguards involved in the Michigan law.

"The Michigan Department of Health laboratories have made 33,584 serological tests for syphilis for marriage license applicants. Of these, 405 were positive for syphilis and 60 were doubtful, reported as plus-minus. The registered laboratories, which are authorized to make these tests, do not report the number of tests which they make but they did report 245 positive and 4 as doubtful. Thus, it appears that slightly more than 1 per cent of all applicants have shown positive indications of syphilis.

"This means that through the operation of this law we have discovered 650 persons who could not be permitted to marry. If the operation of this law has uncovered 650 cases of syphilis it has been well worth while. Many of these cases claim that they had no knowledge of ever having had this disease. Be this as it may, the fact remains that 650 persons could not marry in this state because of syphilitic infection. Certainly this redounds to the benefit of the future generation, and if at least some of these cases were put under treatment, the gain is still greater."

MONTHLY MORTALITY REVIEW

Mortality reports for the first ten months of 1938, compiled by the Bureau of Records and Statistics, show a decline in total deaths from 44,819, in 1937, to 41,707 this year. Infant mortality, too, is down from 3,673, in 1937, to 3,564, in 1938. Maternal deaths slightly exceed last year's figures, when an all-time low rate for this cause was set, but with the current increase in births, the 1938 maternal mortality rate will compare favorably. There were 276 maternal deaths last year, compared to 291 this year. Births have increased from 76,435, in 1937, to this year's total of 80,590 for the ten-month period.

Comparative mortality figures for the major communicable diseases, in 1937 and 1938, are indicated in the table below:

Communicable Disease Mortality
1937-1938

Disease	October, 1938	October, 1937	10 Months, 1938	10 Months, 1937
Pneumonia	218	274	2,271	3,403
Tuberculosis	149	160	1,616	1,816
Typhoid Fever	1	2	20	25
Diphtheria	5	12	32	57
Whooping Cough	7	9	101	114
Scarlet Fever	3	8	74	132
Measles	0	1	96	9
Smallpox	0	0	0	1
Meningitis	2	2	18	37
Polio-myelitis	1	5	8	48
Undulant Fever	0	0	1	0
Syphilis	40	30	318	328
Gonorrhea	0	0	6	7

VENEREAL DISEASE CONTROL COURSE PLANNED

The Michigan Department of Health is making arrangements for a course in venereal disease control for health officers. Plans, as now contemplated, call for a week's intensive instruction in the epidemiological and clinical phases of venereal disease control. The course will be given twice to meet the convenience of all health officers.

CORRESPONDENCE

We received the following communication from Dr. J. R. McIntyre, secretary of the Michigan State Board of Registration in Medicine, Lansing. This interesting letter from the office of the attorney general of the state is self-explanatory.

November 16, 1938

Dear Doctor McIntyre:

We have your letter of November 10 relative to an inquiry directed to your office as to the right of the medical personnel on the staff of hospitals operated by the United States in Michigan to practice medicine.

Section 8 of the Medical Practice Act, being Act 237, Public Acts of 1899, as amended, provides, in part, as follows:

"This act shall not apply to the commissioned surgeons of the United States army, navy or marine hospital service, in actual performance of their official duties,"

It is our opinion that no Michigan license can be required of physicians employed by the Federal government in Michigan whose practice is confined exclusively to the performance of their official duties.

By being so exempt, however, such physicians are not thereby authorized to engage in other practice; and, should any such physician propose to engage in practice outside the scope of his official duties, he is required to be licensed by the Michigan State Board of Registration in Medicine, as any other physician.

We trust the foregoing answers your question.

Very truly yours,

RAYMOND W. STARR
Attorney General

By JOHN H. BRENNAN
Deputy Attorney General

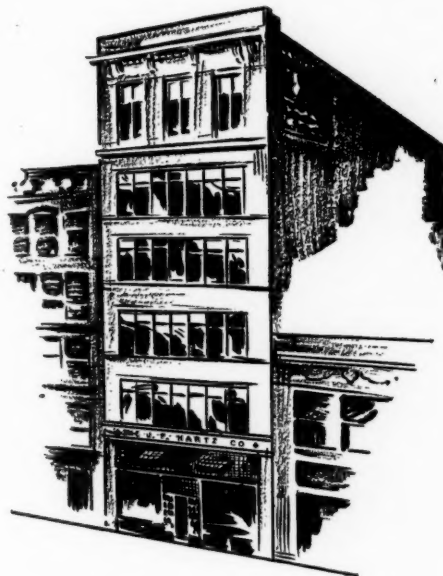
IN MEMORIAM

Dr. S. W. Woyt

Dr. Stanley W. Woyt, a young physician of Jackson, died suddenly as the result of an automobile accident, on November 23. A graduate of the Wayne University Medical School, class of 1930, Dr. Woyt spent his internship in Fort Wayne, Indiana, practiced for a short time in Detroit, and in 1935 opened an office in Jackson. He is survived by his mother and sister.

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General News And Announcements

100 Per Cent Club for 1939

Menominee County Medical Society

Muskegon County Medical Society

The above county medical societies have paid 1939 dues for 100 per cent of their membership. Dues for 1939 are \$12.00 and are now payable. See your County Medical Society Secretary today and help make your Society 100 per cent paid up for 1938.

T. Y. Ho, M.D., of St. Johns was re-elected Secretary of the Clinton County Medical Society for the sixteenth consecutive time.

* * *

T. W. Thompson, M.D., of Traverse City, spoke on "Mental Health with Special Reference to Mental Hygiene," at the annual meeting of the Alpena County Medical Society on December 18, in Alpena.

* * *

C. D. Brooks, M.D., Detroit, addressed the St. Clair County Medical Society at its meeting of December 13 on the subject of "Diagnostic Problems of Acute Abdominal Conditions."

* * *

The International College of Surgeons will hold its Assembly in New York City on May 22, 23 and 24, 1939. Edward Frankel, Jr., M.D., 217 East 17th St., New York, has been appointed General Chairman.

* * *

Cyrus P. Sturgis, M.D., and Frank H. Bethell, M.D., of Ann Arbor, presented an illustrated lecture on "Anemias of Pregnancy" before the Hillsdale County Medical Society at its meeting of December 8.

* * *

The Gratiot-Isabella-Clare County Medical Society's meeting on December 15 was "Ladies' Night." All dentists, editors and hospital supervisors of the three counties were invited guests. The speaker of the evening was L. Fernald Foster, M.D., of Bay City.

* * *

Exhibit space at the 1939 Grand Rapids Convention is being rapidly reserved. The Seventy-Fourth Annual Meeting will be held at the spacious Civic Auditorium which can adequately accommodate every phase of the Convention. The dates are September 18, 19, 20, 21 and 22, 1939.

* * *

The Wayne County Medical Society developed a clever "Inventory" which was distributed to its membership. The "Inventory" set forth in an attractive and interesting manner the scope of activities of the Society and the services rendered to the individual members.

* * *

The Ottawa County Medical Society held its annual meeting in Holland on Thursday, December 15. Members of the dental profession were invited guests. Councilor Vernor M. Moore of Grand Rapids and Secretary L. Fernald Foster of Bay City were guest speakers.

The American Medical Association has initiated a clip-sheet service. Each week the clip sheet, called "American Medical Association News," containing several pages of official announcements, abstracts and condensations of original articles and editorials appearing in *The Journal of the AMA* and *Hygiea*, is sent to publishers.

* * *

A handbook of useful information for members is being developed by a special committee of the Wayne County Medical Society. It will include the Society's By-laws, committees, various rules and procedures, lists of clinics, diagnostic facilities, approved hospitals and sanatoria, certain social agencies, synopses of laws regulating practice, and many other items of information useful to the practitioner.

* * *

G. H. Belote, M.D., of Ann Arbor, is guest speaker on the program of the International Post-Graduate Medical Assembly of Southwest Texas, which will be held in San Antonio on January 24, 25, 26, 1939. Doctor Belote will deliver three lectures on (a) "Hormone Studies in Acne Vulgaris," (b) "Modern Trends in the Treatment of Syphilis," and (c) "Common Drug Eruptions."

* * *

Recent articles by Michigan physicians in the *Journal of the American Medical Association* include "Torsion of the Testicle" by John K. Ormond, M.D., Detroit, issue of November 19; "The Present Status of Ergonovine" by Ralph G. Smith, M.D., Ann Arbor, issue of December 10; and "Red Blood Cell Increase in Pernicious Anemia" by Raphael Isaacs, M.D., F. H. Bethell, M.D., M. C. Riddle, M.D., and Arnold Friedham, of Ann Arbor.

* * *

A Course in Anatomy will be given during the second semester, February 13 to May 30, 1939, one afternoon and evening each week, on Wednesday, 1:00-10:00 P. M., by Professor Rollo E. McCotter. There will be an informal lecture the first part of the afternoon followed by dissection of the part under discussion. Fee \$25. Graduate or post-graduate credit can be arranged. For further information, address: Department of Postgraduate Medicine, University of Michigan, Ann Arbor, Michigan.

* * *

Dr. Clarence A. Lightner, well known to many of the older members of the medical profession of the state, died on December 7, at his home in Tryon, N. C., at the age of seventy-seven. Mr. Lightner taught medical jurisprudence in the Detroit College of Medicine for many years. He was graduated from the University of Michigan in 1883 and practiced law in Detroit. In 1892, he married Frances B. McGraw, daughter of Dr. Theodore A. McGraw, Senior, one of the best known surgeons of Detroit and Michigan in his day.

* * *

Many times a child is scolded for dullness when he should be treated for undernourishment. The scant fare of a "continental" breakfast provided in hundreds of homes may undernourish and leave the child listless, nervous or stupid at school. A solution to this problem is Pablum, Mead's Cereal, cooked and dried. It is six times richer than fluid

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GENERAL NEWS AND ANNOUNCEMENTS

milk in calcium, ten times higher than spinach in iron, and abundant in vitamins B₁ and G. Pabulum furnishes protective factors needed by the school-child and is a valuable aid in increasing the weight.

* * *

The Radio Committee of the M.S.M.S., in collaboration with the Joint Committee on Health Education, sponsored the following radio programs during the months of December and January:

December 5, 1938—"What Is a Goitre?" by Eugene Osius, M.D.

December 12, 1938—"Plastic Surgery," by Claire Straith, M.D.

December 19, 1938—"Pneumonia," by Alvin Price, M.D.

December 26, 1938—"Health and High Blood Pressure," by Thomas McKean, M.D.

January 9, 1939—"Research in Medicine," by Clifford Benson, M.D.

* * *

Ten more of your friends, who displayed their products and services at the 1938 Detroit Convention last September. When you have an order, don't forget your friends!

Holland-Rantos, Inc., New York, New York
Horlick's Malted Milk Corporation, Racine, Wisconsin
The G. A. Ingram Company, Detroit, Michigan
Jones Metabolism Equipment Company, Chicago, Illinois
Jones Surgical Supply Company, Cleveland, Ohio
A. Kuhlman & Company, Detroit, Michigan
Lea & Febiger, Philadelphia, Pennsylvania
Lederle Laboratories, Inc., New York, New York
Libby, McNeill & Libby, Chicago, Illinois
Liebel-Flarsheim Company, Cincinnati, Ohio

* * *

The Philadelphia County Medical Society desires to announce formally, the completion of its scientific program for the fourth annual postgraduate institute to be held in the Bellevue-Stratford Hotel, Philadelphia, during the week beginning March 13th, 1939. The subjects to be considered are those embraced by the terms BLOOD DYSCRASIAS and METABOLIC DISORDERS. These will be further subdivided

for convenience in instruction into eighty-six clinical lectures, with open forum discussion for each topic, delivered by as many individual specialists of national distinction.

* * *

S. M. Keenan, a pioneer in the x-ray field in Detroit, died December 8. Mr. Keenan had been connected with the Eloise Hospital for more than forty years, during which time he acquired an extensive collection of x-ray equipment, including tubes of the Crookes type to the very modern apparatus of the present time. Mr. Keenan was born in Brock, Ontario, in 1862, received his B.A. degree from the Detroit College in 1888, also his M.A. in 1896. He was an active member of many organizations, including the Michigan Academy of Science, the American Association for the Advancement of Science, the Detroit Roentgen Ray and Radium Society, and the Roentgen Ray Society.

* * *

Afflicted Child Commitments for month of November, 1938:

Total cases, 1,746, of which 210 were sent to University Hospital and 1,536 were sent to miscellaneous local hospitals. From Wayne County, of the above, 24 went to University Hospital and 348 went to local miscellaneous hospitals, total 372.

Crippled Child: Total cases 305, of which 93 were sent to University Hospital and 212 to miscellaneous hospitals. From Wayne County, included in the above, 5 went to University Hospital and 47 to miscellaneous hospitals, total of 52 cases.

* * *

The American Board of Ophthalmology has announced a change in method of examination of candidates for the Board's certificate. The examination will be in two parts, the written examination

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to be given sixty days prior to the oral examination which will be given at the time and place of the meeting of the American Medical Association and of the American Academy of Ophthalmology and Oto-Laryngology. Candidates must pass the written examination before they may take the oral. The examinations scheduled for 1939 are Written, March 15 and August 5, in various cities throughout the country; and Oral, St. Louis, May 15, and in Chicago, October 6. Write John Green, M.D., 6830 Waterman Ave., St. Louis, Mo., for application forms and further information.

* * *

New county medical society secretaries have been elected for 1939 as follows:

E. S. Parmenter, M.D., Alpena, Secretary of the Alpena County Medical Society
H. R. Mooi, M.D., Union City, Secretary of the Branch County Medical Society
D. R. Smith, M.D., Iron Mountain, Secretary of the Dickinson-Iron County Medical Society
F. L. S. Reynolds, M.D., Ironwood, Secretary of the Gogebic County Medical Society
A. F. Litzenger, M.D., Boyne City, Secretary of Northern Michigan Medical Society
W. P. Petrie, M.D., Caro, Secretary of the Tuscola County Medical Society

* * *

Laboratory studies and clinical investigations have shown that diphtheria and tetanus toxoids when given at the same time act independently and effectively in the production of their respective antitoxins. The Eli Lilly Laboratories have devised a method of preparing in a single solution the combined alum precipitated toxoids. Two doses of 0.5 c.c. given three to six months apart produce satisfactory immunity within six months after the last injection. If the person immunized should subsequently receive an injury through which tetanus spores might enter the tissues, a stimulating dose of 0.5 c.c. tetanus alum precipitated toxoid should be given. It is advantageous to have reasonable assurance of protection in a large percentage of immunized cases and to be able to avoid serum sensitization from antitoxin administration, which should strongly commend tetanus immunization.

* * *

American Board of Obstetrics and Gynecology.—The general oral, clinical and pathological examinations for all candidates, Part II Examinations (Groups A and B), will be conducted by the entire Board, meeting in St. Louis, Missouri, on May 15 and 16, 1939, immediately prior to the annual meeting of the American Medical Association. Notice of time and place of these examinations will be forwarded to all candidates well in advance of the examination dates.

Candidates for reexamination must request such reexamination by writing the Secretary's Office before the following dates: Part I—January 1, 1939; Part II—April 1, 1939. Candidates who are required to take reexaminations must do so before the expiration of three years from the date of their first examination.

Application for admission to Group A, May 1939, examination must be on file in the Secretary's Office by March 15, 1939.

Application blanks and booklets of information may be obtained from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

* * *

A cancer center in Detroit was announced last month. Wayne University Medical School and a number of hospitals, notably Receiving, Grace and Woman's Hospitals, will give clinical training in diagnosis and treatment of malignancies. The

GENERAL NEWS AND ANNOUNCEMENTS

announcement was made by Dr. Ludvig Hektoen of the United States Public Health Service. The work will be open to graduate physicians who are interested in cancer specialization. A three-year training period at these hospitals is announced. Appointments for training will be made by the United States surgeon-general from nominations made by the national cancer advisory council. The following local men are named as instructors: Dr. Edgar H. Norris, professor of pathology at Wayne University, and Dr. Osborn Brines, Assistant Professor at Wayne University Medical School, will teach pathology; Dr. Rollin Stevens and Dr. Clarence I. Owen of Grace Hospital and Dr. Harry Nelson, professor and director of the hospital tumor clinic, and Dr. Frances A. Ford of the Woman's Hospital have been appointed instructors. Dr. Charles G. Johnston, professor of surgery of the Wayne University Medical School, will deal with the subject of general surgical experience at Receiving Hospital.

* * *

Of Interest to the Ophthalmologist

The amount of eye material in any one institution is small. It is hoped by pooling this material from many hospitals to build up a collection of pathological eye material. Properly prepared and diagnosed this will enable Pathologists and Ophthalmologists in this part of the country to advance their knowledge of ocular pathology to an extent which has hitherto not been possible.

It is proposed to keep on permanent file in the ophthalmic research laboratory of Wayne University Medical School, available for study by Ophthalmologists and Pathologists, an adequate number of slides, together with the unused portions of the specimens, and cross-indexed data obtained from the case history and from the report of the specimen. Sample slides and a copy of this laboratory's report in duplicate will be returned to the source of the material. The Pathologist can confirm diagnosis and make his report in the usual way. If the block is desired or if additional slides are wanted, this will ordinarily be possible if requested.

The Pathologists and Ophthalmologists of Hospitals interested in this free service on ophthalmic material may communicate with the Ophthalmic Research Laboratory, Wayne University, College of Medicine, 1512 St. Antoine St., Detroit.

* * *

The Madge Sibley Hoobler Home

The Madge Sibley Hoobler Home, located at 25300 W. McNichols Road in Detroit, stands as a memorial to the late Mrs. Hoobler, wife of Dr. Raymond B. Hoobler, Detroit pediatrician, well known to the profession in Michigan. The Madge Sibley Hoobler Home is a guest house for convalescent girls. It was proposed by the late Mrs. Hoobler, who died over two years ago. The Hoobler Home can accommodate twenty-five guests, who may spend as long as two weeks, without expense, in an atmosphere of quiet refinement and healthy living. The house is organized as a non-profit corporation. On its Women's Board of Directors are Miss Charlotte Waddell, chairman, superintendent of Women's Hospital; Miss Walker; Mrs. H. R. Crowell, of First Presbyterian Church, in charge of religious and social activities; Mrs. W. B. Cooksey, head of the Detroit Girl Scouts and in charge of outdoor activity; Mrs. Josephine Powers; Mrs. Allen B. Crow; and Mrs. Icie Macy Hoobler, Dr. Hoobler's wife.

On the advisory board are William J. Norton, chairman, head of the Michigan Children's Fund; Clarence W. Wilcox, attorney for the fund; Stew-

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GYNECOLOGY—Two Weeks Course starting February 27, 1939. Clinical and Personal Courses starting every week.

OBSTETRICS—Two Weeks Intensive Course starting March 13, 1939. Informal Course starting every week.

FRACTURES & TRAUMATIC SURGERY—Informal Course every week; Intensive Ten Day Course starting February 13, 1939.

OTOLARYNGOLOGY—Two Weeks Intensive Course starting April 10, 1939. Informal Course starting every week.

OPHTHALMOLOGY—Two Weeks Intensive Course starting April 24, 1939. Informal Course starting every week.

CYSTOSCOPY—Ten Day Practical Course rotary every two weeks.

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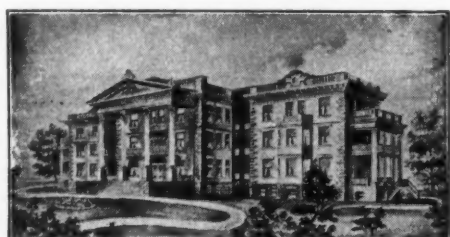
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art Hamilton, superintendent of Harper Hospital; L. A. Ewald, A. B. Hoskin, and Dr. W. B. Cooksey of the Harper staff. The guest house staff includes Mrs. Norma Selbert, director; Miss Dorothy Waddell, Mrs. Sue Wicher and Dr. Fanny Kenyon.

* * *

Forum on Allergy

Physicians interested in allergy are invited to attend the North Central Forum on Allergy to be held at the Commodore Perry Hotel, Toledo, Sunday, January 15.

The meeting will open with an informal "get-together" Saturday evening, January 14, at the Commodore Perry Hotel. Physicians planning to attend the Forum are urged to arrive in time for this social session which may be the high-light of the meeting.

The program for the two sessions, Sunday, January 15, follows:

Morning Session, 10:00 A. M.

1. Food Allergy
"Diagnostic Measures," by Dr. Samuel M. Feinberg, Chicago; discussants, Dr. M. A. Weitz, Cleveland, and Dr. Sam Levine, Detroit.
"Value of Skin Tests in Diagnosis of Food Allergy," by Dr. George Waldbott, Detroit; discussants, Dr. Albert Zoss, Cincinnati, and Dr. I. M. Hinnant, Cleveland.
"Dietary Management of Food Allergy," by Dr. Jonathan Forman, Columbus; discussants, Dr. David M. Cowie, Ann Arbor, and Dr. George L. Lambright, Cleveland.
 2. "Drug Hypersensitivity," by Dr. John H. Mitchell, Columbus; discussants, Dr. Barney Credille, Flint, and Dr. Frank Menagh, Detroit.
- Luncheon—Crystal Room, Commodore Perry Hotel.

Afternoon Session, 2:00 P. M.

- "Preparation of Protein Extracts," by Dr. Milton B. Cohen, Cleveland; discussants, Dr. Leon Unger and Dr. Tell Nelson, Chicago.
"Preparation of Plant Oil Extracts for Diagnosis and Treatment," by Dr. L. E. Seyler, Dayton; discussants, Dr. John Sheldon, Ann Arbor, and Dr. Wm. P. Carver, Cleveland.

(Papers limited to ten minutes each; discussants limited to five minutes.)

This meeting was planned to foster acquaintance and exchange of ideas of members of the Cleveland, Chicago, Michigan and Ohio Valley Society of Allergists. However, any physicians, in good professional standing, who are interested in allergy are most welcome.

Further information can be obtained by addressing Dr. Karl D. Figley, 316 Michigan Street, Toledo, Ohio.

* * *

Dr. Vaughan Honored

Dr. Henry F. Vaughan will have completed twenty-five years of service with the Detroit Department of Health on January first.

Dr. Vaughan was born in Ann Arbor, on October 12, 1889, the son of Dr. and Mrs. Victor C. Vaughan. He received his primary and high school education in Ann Arbor, followed by a year at Chateau de Lancy, at Geneva, Switzerland, before entering the University of Michigan, from which he received three degrees, Bachelor of Science in engineering in 1912, M.S. in the same field in 1913 and Doctor of Public Health in 1915.

He was Assistant Sanitary Engineer for the Michigan Department of Health from 1913 to 1914 and in 1914 he came to the Detroit Department of Health as Sanitary Engineer and Assistant Health Officer. When the United States went into the war he became a captain in the sanitary corps of the

(Continued on page 78)

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United States army and was released to become Commissioner of Health in 1918. He has been president of the American Public Health Association, and has served for many years on the Governing Council of that organization. Since 1915, he has been associate professor of public health at Wayne University, and since 1921 special lecturer at the University of Michigan.

He is an associate member of the Wayne County Medical Society and an honorary member of the Detroit District Dental Society. He has contributed many articles on public health and is joint author, with his father and Dr. George T. Palmer, of "Epidemiology in Public Health."

Physicians throughout the country have learned to respect Dr. Vaughan for his appreciation of the part played by the private practitioner of medicine in promoting public health. His cooperative plan with the Wayne County Medical Society, which has been entitled "Medical Participation in Public Health," has been watched and adopted in an increasing number of localities.

On Thursday evening, January twelfth, at 7:00 o'clock, the staff of the Detroit Department of Health will honor Dr. Vaughan at a subscription dinner, to which physicians in Detroit are invited. Tickets may be obtained from the executive offices of the Wayne County Medical Society or the office of the secretary of the Department of Health.

* * *

CREDIT IS DUE

The following members of the Michigan State Medical Society were present at the postgraduate assemblies of the Michigan State Medical Society Annual Meeting, Detroit, September 19, 20, 21, 22, 1938.

Agnelly, Ed. J.—Detroit
Allen, R. C.—St. Joseph
Amberg, Emil—Detroit
Andrew, F. T.—Kalamazoo
Andries, R. C.—Detroit
Appel, Philip R.—Detroit
Arnold, A. L., Jr.—Owosso

Badgley, C. E.—Ann Arbor
Bailey, Louis J.—Detroit
Baker, H. B.—Detroit
Bakst, Joseph A.—Detroit
Balser, Chas. W.—Detroit
Barnett, S. E.—Detroit
Barnes, Donald J.—Detroit
Barrett, Joseph E.—Lansing
Barrett, W. D.—Detroit
Barstow, W. E.—St. Louis
Barton, J. R.—Detroit
Bates, Gaylord S.—Detroit
Beck, Otto S.—Birmingham
Becker, Myron G.—Edmore
Biegler, Sydney K.—Detroit
Bell, William M.—Detroit
Benning, C. H.—Royal Oak
Berman, Harry S.—Detroit
Bernstein, A. E.—Detroit
Best, H. M.—Lapeer
Bicknell, N. J.—Detroit
Biddle, Andrew P.—Detroit
Blaess, Marvin J.—Detroit
Blain, A. W.—Detroit
Blanchard, F. N.—Detroit
Boyd, D. R.—Muskegon
Bradley, J. B.—Eaton
Rapids

Braley, W. N.—Detroit
Brasie, Donald R.—Flint
Brisbois, H. J.—Plymouth
Brook, J. D.—Grand Rapids
Brown, Henry S.—Detroit
Brown, I. W.—Kalamazoo
Bruehl, Richard A.—Detroit
Brunk, A. S.—Detroit
Brunk, C. F.—Detroit
Brunson, E. T.—Ganges
Budler, Samuel A.—Pontiac
Budson, Daniel—Detroit
Buesser, Fred G.—Detroit
Burch, L. J.—Mt. Pleasant
Burley, J. H.—Port Huron
Byington, G. M.—Detroit

Caldwell, J. Ewart—Detroit
Carlucci, Peter F.—Detroit

Carstens, Henry R.—Detroit
Caster, E. W.—Mt. Clemens
Catherwood, A. E.—Detroit
Chase, A. W.—Adrian
Cheney, G. C.—Detroit
Christian, L. G.—Lansing
Christopoulos, D. G.—Detroit

Clark, Harold E.—Detroit
Clark, Harry L.—Detroit
Clarke, George L.—Detroit
Clinton, Wm. R.—Detroit
Cole, Fred H.—Detroit
Conrad, G. A.—Sault Ste. Marie
Cook, Henry—Flint
Cooksey, W. B.—Detroit
Cooper, James B.—Detroit
Corbus, Burton R.—Grand Rapids
Cree, Walter J.—Detroit
Cruikshank, Alex.—Detroit
Cummings, H. H.—Ann Arbor
Curhan, Joseph H.—Detroit

D'Alcorn, E.—Muskegon
Danforth, M. E.—Detroit
Davis, C. R.—Detroit
Day, Luther W.—Jonesville
Defnet, Wm. A.—Detroit
DeGurse, T. E.—Marine City

Dempster, J. H.—Detroit
Denman, Dean C.—Monroe
DeVries, C. F.—Lansing
Dibble, Harry F.—Detroit
Donald, Douglas—Detroit
Doyle, Fred M.—Kalamazoo
Doyle, George H.—Detroit
Dubpernell, M. S.—Detroit
Dunn, Cornelius—Detroit
Dutchess, Chas. E.—Detroit

Ellet, Wm. C.—Benton Harbor

Fenech, Harold B.—Detroit
Fenton, Edw. H.—Detroit
Finch, Russell L.—Lansing
Fisher, G. F.—Hastings
Fitzgerald, E. W.—Detroit
Folsome, C. E.—Ann Arbor
Forbes, Edwin B.—Detroit
Forrester, A. V.—Detroit

Foster, L. F.—Bay City
Foster, Owen C.—Detroit
Foss, Edwin O.—Muskegon
Frailick, F. B.—Ann Arbor
Frazier, Mary M.—Detroit
Freese, John A.—Detroit
Friedlaender, B.—Detroit
Fyvie, J. H.—Manistique

Garner, Howard B.—Detroit
Geib, L. O.—Detroit
Gelber, S.—Detroit
Gellert, I. S.—Detroit
Gonne, Wm. S.—Detroit
Gordon, W. H.—Detroit
Gould, S. E.—Detroit
Grant, L. E.—Detroit
Greene, I. W.—Owosso
Grossman, S. C.—Detroit
Gruber, T. K.—Eloise

Hackett, Walter L.—Detroit
Hafford, A. L.—Albion
Hafford, George C.—Albion
Hall, James A. J.—Detroit
Hansen, H. C.—Battle Creek

Harkness, R. B.—Hastings
Harm, W. B.—Detroit
Harrison, Henry—Detroit
Hart, C. D.—Newberry
Hart, Dean W.—St. Johns
Hartman, F. V.—Detroit
Harvie, L. C.—Saginaw
Hasley, C. K.—Detroit
Hasner, R. B.—Royal Oak
Haughey, W.—Battle Creek
Heavenrich, T. F.—Port Huron

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Hewitt, Leland V.—Detroit
Hirschman, L. J.—Detroit
Hodge, James B.—Detroit
Hoffman, T. E.—Vassar
Hoffmann, M. H.—Eloise
Holly, L. E.—Muskegon
Holmes, R. H.—Muskegon
Hookey, J. A.—Detroit
Howlett, R. R.—Caro
Hubbell, R. J.—Kalamazoo
Huntington, H. G.—Howell

Imthun, E.—Grand Ledge
Insley, Stanley W.—Detroit
Isaacs, J. C.—Detroit
Isaacson, Arthur—Detroit
Jackson, C. C.—Imlay City
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Jamieson, R. C.—Detroit
Jonikaitis, J.—Detroit
Johnson, L. J.—Ann Arbor
Johnston, E. V.—Detroit
Johnstone, Ben I.—Detroit

Kay, Harry H.—Detroit
Keane, William E.—Detroit
Kelsey, Lee—Lakeview
Kennedy, Wm. Y.—Detroit
Keyport, C. R.—Grayling
Kilroy, J. Frank—Detroit
Kirschbaum, Harry—Detroit
Kirtin, J. R. W.—Calumet
Klein, William—Detroit
Klingman, S.—Detroit
Kliger, David—Detroit
Kniskern, Paul W.—Grand Rapids
Krebs, Wm. T.—Detroit

Laird, R. Lee—Detroit
Lampman, H. H.—Detroit
Lang, W. W.—Kalamazoo
Lawrence, Wm. C.—Detroit
Ledwidge, P. L.—Detroit
Lemen, C. E.—Traverse City
LeMire, W. A.—Escanaba
Lemmon, C. E.—Detroit
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Lippold, Paul H.—Detroit
Livingston, G. M.—Detroit
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McAlpine, A. E.—Detroit
McCall, J. H.—Lake City
McClellan, G. L.—Detroit
McDonald, Allan—Detroit
McIntyre, J. Earl—Lansing
McKean, R. M.—Detroit
Manthei, W. A.—Lake Linden

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Mertaugh, W. F.—Sault Ste. Marie
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Miller, J. D.—Grand Rapids
Mishelevich, Sophie—Detroit
Moisides, V. P.—Detroit
Moore, Vernor M.—Grand Rapids

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Murphy, Frank J.—Detroit
Neumann, A. J.—Detroit
Novy, R. L.—Detroit

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O'Brien, D. J.—Lapeer
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Osius, Eugene A.—Detroit
Osterlin, Max F.—Traverse City

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Pearse, Harry A.—Detroit
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Perkins, Roy C.—Bay City
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Pinkus, Hermann—Detroit
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Plaggemeyer, H. W.—Detroit

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Robb, Herbert F.—Belleville
Robinson, R. G.—Detroit
Rosen, Robert—Detroit
Rubright, L. W.—Detroit
Rupp, Jacob Roth—Detroit
Russell, T. P.—Centerline

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Sage, E. O.—Detroit
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Sawyer, Harold F.—Detroit
Scher, J. N.—Mt. Clemens
Schreiber, Frederic—Detroit
Scrafford, R. E.—Bay City
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Scott, Robt. D.—Flint
Segar, Laurence F.—Detroit
Seibert, A. H.—Detroit
Selmon, B. L.—Battle Creek
Sethney, H. T.—Menominee
Shafarman, E. M.—Detroit
Shaffer, Loren W.—Detroit
Shawan, H. K.—Detroit
Sheldon, Suel A.—Saginaw
Sherman, B. B.—Detroit
Sherman, Geo. A.—Pontiac
Sherwood, D. L.—Detroit
Shulak, Irving B.—Detroit
Simpson, C. E.—Detroit
Skully, G. A.—Detroit
Sladek, E. F.—Traverse City

Slevin, John G.—Detroit
Small, Henry—Detroit
Smeck, A. R.—Detroit
Smith, D. R.—Iron Mountain

Smith, W. Joe—Cadillac
Snapp, Carl F.—Grand Rapids
Souda, Andrew—Wyandotte
Southwick, G. Howard—Grand Rapids

Southwick, S. W.—Detroit
Spalding, Edw. D.—Detroit
Spears, M. L.—Pontiac
Spinks, R. E.—Newberry
Springer, R. A.—Centerville
Stapleton, Wm. J.—Detroit
Stern, Louis D.—Detroit

GENERAL NEWS AND ANNOUNCEMENTS

Stickley, A. E.—Coopersville
 Straith, Claire L.—Detroit
 Strong, W. F.—Ontonagon
 Stryker, O. D.—Fremont
 Sugar, David I.—Detroit
 Sutton, P. E.—Royal Oak

Tatellis, G. A.—Detroit
 Thompson, Alvin—Flint
 Torgerson, Wm. R.—Grand Rapids
 Toshach, Clarence—Saginaw
 Tuck, R. G.—Pontiac

Umpfrey, C. E.—Detroit
 Urnston, P. R.—Bay City

Valade, Cyril K.—Detroit
 Vale, C. Fremont—Detroit
 Vandeventer, V. H.—Ishpeming
 VanRhee, Geo. H.—Detroit
 Vaughan, Henry F.—Detroit
 Vonder Heide, E. C.—Detroit

Wade, R. L.—Coldwater
 Waldie, Geo. M.—Hancock
 Walker, Roger V.—Detroit
 Ward, William T.—Detroit
 Weber, Karl W.—Detroit
 Webster, J. C.—Marlette
 Weller, C. N.—Detroit
 Wenger, A. V.—Grand Rapids

Wessinger, John A.—Ann Arbor
 Wiley, Harold W.—Lansing
 Willison, Clayton—Sault Ste. Marie
 Wishropp, Edw. A.—Detroit
 Wittenberg, Samson S.—Detroit
 Witwer, E. R.—Detroit
 Woodworth, W. P.—Detroit

Yeo, G. H.—Big Rapids
 Yates, H. W.—Detroit
 Yeomans, T. G.—St. Joseph
 Zindler, George A.—Detroit

The above list represents the registration of Monday, September 19, 1938. The registration of Tuesday, Wednesday, and Thursday will be published in succeeding issues of THE JOURNAL.

Abstracts in the Field of Physical Therapy

Blackman, W. W., and Richardson, J. L.: Diathermy in Coronary Thrombosis. Arch. Physical Ther., 21:412 (July), 1938.

Short wave diathermy is the most efficient and reliable agent available for improving the blood supply to the myocardium in coronary thrombosis. Clinical and electrocardiographic evidence shows that short wave diathermy through the region of the heart allays arterial spasm, induces coronary dilatation and develops new blood pathways.

Hansel, F. K.: Status of Ionization in Nasal Allergy. Arch. Phys. Ther., 21:489, (August) 1938.

According to leading rhinologists, ionization of the nasal mucosa is safe and satisfactory in the treatment of hay fever and nasal allergy. According to observation of leading allergists, ionization does not give results comparable to those obtained by allergic methods of treatment. A few rhinologists have reported results from escharotics equally as satisfactory as those obtained by ionization. It is generally concluded that ionization in nasal allergy should be confined to those cases in which allergic methods of treatment have failed to give satisfactory relief of symptoms. The selection of cases for this type of treatment, therefore, should be made by the close coöperation of the allergist and the rhinologist, or by the rhinologist adequately familiar with the practice of allergy.

Osborne, S. L., Blatt, M. L., and Neymann, C. A.: Electropyraxia in Rheumatic Carditis, Chorea and other Childhood Diseases. Physio-Therapy Rev. 18:68, (March-April) 1938.

The authors treated twenty-five patients suffering from chorea minor, seven of whom had rheumatic carditis. The authors feel that fever is not contraindicated where a heart lesion is present because all the patients were poorly nourished and poor risks and had nothing happen to them from the fever treatments. Treatment is carried out in 8 hour sessions at a temperature about 104 F. Rheumatic carditis. The authors feel that fever is benefited by artificial fever therapy. The choreiform movements of Sydenham's chorea cease in 88 per cent of the cases treated. The movements stop after an average of four sessions, which justifies the belief that the disease is aborted and will not recur.

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Acknowledgment of all books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.

SPINAL ANESTHESIA. By Louis H. Maxson, A.B., M.D. Practicing specialist in anesthetics, formerly Chief Anesthetist, Harborview Hospital, Seattle, Washington, with a foreword by W. Wayne Babcock, M.D., LL.D., F.A.C.S., Professor of Surgery, Temple University School of Medicine, with illustrations. Philadelphia and New York: J. B. Lippincott Company, 1938.

"The dangers of spinal anesthesia lie with the user, more than with the drug," writes Dr. Wayne Babcock, as a preface to a plea for skill on the part of the spinal anesthetist. This work of over 400 pages discusses every phase of the subject of spinal anesthesia, including anatomical considerations, physical factors, drugs, technical considerations, special technic and technical difficulties, dangers, complications, advantages and disadvantages.

DISEASES OF THE NOSE, THROAT AND EAR. By W. Wallace Morrison, M.D. Clinical Professor, and Chief of Clinic, Department of Otolaryngology, New York Polyclinic Medical School and Hospital, illustrated. Philadelphia and London: W. B. Saunders Company, 1938.

This work is based upon fifteen years of teaching the subject of otolaryngology to postgraduate students. This fact should recommend it to the general practitioner as well as the specialist, for, while otolaryngology is a specialty, there are certain phases, particularly the acute stages, which the general practitioner should understand. The work is well illustrated by pen drawings and zinc etchings, evidently made to illustrate the particular subject under discussion. The usual method is followed, namely, of prefacing the subject with full description of anatomy and physiology. The work can be heartily recommended.

MARIHUANA, AMERICA'S NEW DRUG PROBLEM. By Robert R. Walton, Professor of Pharmacology, School of Medicine, University of Mississippi, with a foreword by E. M. K. Geiling, Professor of Pharmacology, University of Chicago, and a chapter by Frank R. Gomila, Commissioner of Public Safety, New Orleans, and M. C. Gomila Lambou, Assistant City Chemist. Philadelphia: J. B. Lippincott Company, 1938. Price \$3.00.

This little work of 223 pages will doubtless supply all the information on the subject that anyone may desire. The authors are exceedingly well qualified by position and training to write authoritatively on the subject.

ENDOCRINE THERAPY IN GENERAL PRACTICE. By Elmer L. Sevringhaus, M.D., F.A.C.P. Professor of Medicine, University of Wisconsin, Madison, Wisconsin; Editor, Department of Endocrinology, The Year Book of Neurology, Psychiatry & Endocrinology, Chicago: The Year Book Publishers, Inc., 1938.

This is a much abridged treatise on the use of some of the known, effective secretions of the endocrine glands that are available. Since this is a work designed for the general practitioner, much of the knowledge concerning these glands has been reserved for more complete works on this subject. Even those general practitioners who desire to do intelligent work in this field will find it to their advantage to refer to the works which more completely cover the subject.

A TEXTBOOK OF BACTERIOLOGY. Thurman B. Rice, A.M., M.D., Professor of Bacteriology and Public Health at the Indiana University School of Medicine. Second Edition, Revised. 563 pages with 121 illustrations. Philadelphia and London: W. B. Saunders Company, 1938. Cloth, \$5.00 net.

As in previous editions, the author has attempted to make this work a text for students and practi-

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tioners. He has designed it as an aid for the interpretation of disease, rather than a book for the identification of bacteria. He has held the descriptions of the morphology and the cultural characteristics of bacteria to the essentials, leaving detailed information for more voluminous works. Such newer subjects as the typing of pneumococci, the use of sulphanilamide, and of tetanus alum-toxoid are included in this work.

The book appeals to the practitioner as a valuable addition to his reference library.

THE 1938 YEARBOOK OF GENERAL MEDICINE.
Edited by George F. Dick, M.D., J. Burns Amberson, Jr., M.D., George R. Minot, M.D., S.D., F.R.C.P. (Hon.) Edin., William B. Castle, M.D., A.M., M.D. (Hon.) Utrecht, William D. Stroud, M.D., George B. Eusterman, M.D. Chicago: The Year Book Publishers, Inc., 1938.

The Year Book Series in the various departments of medicine and surgery have won for themselves a unique place in the estimation of the medical profession. The science of medicine in all its branches progresses so rapidly that a sifting of values each year is a necessity. When this is done by outstanding authorities in the various subjects, the product is of inestimable worth. The above mentioned names as authors should commend the 1938 Yearbook to every internist and general practitioner. The work comprises 840 pages of reading matter with 178 illustrations in the way of halftones and charts. This work cannot be too highly recommended as a presentation of the latest achievements in medicine.

DISEASES OF THE SKIN FOR PRACTITIONERS AND STUDENTS: By George Clinton Andrews, A.B., M.D., Associate Professor of Dermatology, College of Physicians and Surgeons, Columbia University; Chief of Clinic, Department of Dermatology, Vanderbilt Clinic;

Fellow of the American Medical Association, of the American College of Physicians, and of the New York Academy of Medicine. Second Edition, entirely reset. 899 pages with 938 illustrations. Philadelphia and London: W. B. Saunders Company, 1938. Cloth, \$10.00 net.

The second edition of this work contains seventy-five new diseases of the skin. The author has added chapters on dermatoses due to filterable viruses, vitamin deficiencies and cutaneous infiltration with products of metabolism. The author has gone into the subject of therapy very thoroughly and has added several hundred items such as prescriptions, sensitization tests and discussions of allergy. The work opens with chapters on dermatological anatomy and general pathology. The various skin diseases are grouped. The writer has given detailed instructions in regard to the indications and technic of radium and x-ray therapy. The work is well illustrated and of convenient size. Such works are usually written with the general practitioner in mind and as textbooks for medical students. This work is ideal for both classes of reader. The dermatologist will also peruse it with interest.

INTERNAL MEDICINE: ITS THEORY AND PRACTICE in Contributions by American Authors, Edited by John H. Musser, B.S., M.D., F.A.C.P., Professor of Medicine in the Tulane University School of Medicine, New Orleans. Third edition, thoroughly revised. Illustrated. Pages 1,426. Philadelphia: Lea & Febiger, 1938.

The second edition of this work appeared four years ago. The third edition has been thoroughly revised. This is not an easy task when it is considered that it is a work of composite authorship (twenty-seven contributors). The very fact of multiple authorship, however, will assure the reader of thoroughness in the revision since each contributor has been selected for the special emphasis he places on the subject dealt with. The former



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editions are too well known as well as the editor to call for extended introduction. The book will be found not only a convenient single volume practice (for it is printed in clear type on light paper) but an authoritative work up to the minute on internal medicine.

CANCER, ITS DIAGNOSIS AND TREATMENT. By Max Cutler, M.D., Associate in Surgery, Northwestern University Medical School, and Franz Buschke, M.D., Assistant Roentgenologist, Chicago Tumor Institute, assisted by Simeon T. Cantril, M.D., Director, Tumor Institute Swedish Hospital, Seattle. Pages 753, illustrated. Philadelphia and London: W. B. Saunders Company, 1938.

One expressed object of this work is to clarify opinion arising out of the controversial literature on the subject of neoplastic disease. Recognized authorities and leading clinics hold diametrically opposite views upon the management of some of the most common forms of the disease (cancer), write the authors. The whole field of malignancy is still beset with difficulties, not only in diagnosis but also treatment, particularly when the x-rays and radium are employed with our still uncertain knowledge of their action. The work discusses regional manifestations of cancer such as skin, lip, tongue, pharynx, including every organ in the body as well as nearly fifty pages to bone tumors. Thirty-four pages are devoted to radiation therapy, that is radiation by x-rays and radium. In the matter of x-ray treatment, the author not only discusses indications but draws attention to late manifestations requiring caution, particularly in regard to possible injuries. The work is a full, almost exhaustive, treatise of malignancy which can be recommended unhesitatingly to the entire medical profession.

A BIOLOGICAL APPROACH TO THE PROBLEM OF ABNORMAL BEHAVIOR. By Milton Harrington, M.D. 455 pages. The Science Press Printing Company, 1938.

In 1934, Doctor Harrington published a volume entitled "Wish-Hunting in the Unconscious" in which he set forth his criticisms of Freudian Psychology. His purpose in the present publication is to present the psychology which he would offer in the place of psycho-analysis. Instead of devoting himself exclusively to this objective he continues throughout the book to attack the psychology of Sigmund Freud.

The book is divided into three parts. After fifty-two pages of First Principles, there follow two hundred and three pages about the mind and the remainder of the volume concerns psychopathology. The author advances no new psychological theories in this publication and much of the material is a repetition of that which has been presented in previous text books on this subject. Doctor Harrington's nuclear theme is contained in the following statement: "We believe that all forms of

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behavior are produced by the action of an anatomical mechanism, and that abnormality of behavior occurs because of the inadequacy of this mechanism, by reason of which it sometimes fails to respond in a satisfactory way to the demands made upon it." To attribute all our thoughts, feelings and actions "to the workings of the anatomical mechanism which functions in accordance with definite and fixed laws," seems, in the opinion of this reviewer, to deny the existence of individuality, to neglect the effects of experience, and to ignore the whole concept of human personality. The author's psychology is so mechanistic that he repeatedly compares the behavior of people to the workings of mechanical devices and his arguments are naturally far from convincing. Such statements as the following are contradictory to the facts of everyday experience: "When afraid, for example, one forces himself to assume a bold and aggressive attitude and the fear disappears." Similarly, the author states "when angry, one inhibits the impulse to clench his fists, to scowl, to grit his teeth, and to speak angrily. Instead he compels his body to relax, he smiles, speaks in gentle tones and extends his hand in friendly gesture. In behaving in this way, one frees himself from the emotion of anger, because he frees himself from the postural stimulus by which the emotion of anger is maintained." Everyone knows that we often attempt to hide our feelings from others but no one believes that such concealment causes elimination of the emotions we experience. To agree with the author one would have to believe that human beings possess truly magical powers. This book is not a contribution to a better understanding of abnormal behavior. It is but another attempt to argue with Freud.

—LEO H. BARTEMEIER.

YEARBOOK OF PHYSICAL THERAPY. Richard Kovacs. Chicago: Year Book Publishers, 1938.

This volume of the Year Book Publishers is an outstanding contribution of the fast increasing literature in the field of physical therapy. Richard Kovacs has been one of the leaders and prolific writers in physical therapy, and is well equipped by experience to attempt a review of all the material which has been published in this field during the past year. The first section of the book deals with physical therapy methods, and with general discussions of the physics, dosage and clinical applications. Of particular interest in this section is the discussion of electrophoresis, and its application in the treatment of arthritis. The different phases of physical therapy—electrotherapy, artificial fever therapy, light therapy, balneotherapy and climatotherapy, massage and exercise, physical education and institutional work—are discussed from the current literature of the past year. The second part of the book deals with the practical applications of the various physical modalities. Adequate space is devoted to the application of physical therapeutic measures in cardiovascular conditions, peripheral vascular disease, pulmonary and abdominal conditions, arthritis and rheumatic conditions, traumatic and orthopedic conditions, paralyzes, neurologic and mental conditions, and general discussions on pediatric, gynecologic, genito-urinary, venereal (gonorrhea and syphilis), proctologic, dermatologic, ophthalmologic and nose and throat conditions. This book is of value to both the general practitioner and specialist in that it reviews all recent literature in the treatment of disease by physical modalities. The author is to be highly commended for his efforts in compiling and so well arranging the literature in book form. Reading is easy, and information is practical. All in all this book constitutes a real addition to good reading matter in the field of physical therapy.

NEW AND NONOFFICIAL REMEDIES, 1938. Containing descriptions of the Articles Which Stand Accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1938. Cloth. Price, \$1.50. pp. 592, LXVI. Chicago: American Medical Association, 1938.

New substances described in this volume are Sulfanilamide and Protamine Zinc Insulin, with the accepted brands. The proved value of these new additions to the physician's armamentarium bids fair to make the past year a milestone in therapeutic progress. The Council is to be congratulated on the promptness with which it evaluated these drugs and established standards for their adequate control. From the first the Council warned against using Sulfanilamide in untried combinations. The sad tragedy of the deaths from the rashly introduced Elixir of Sulfanilamide-Massengill starkly emphasizes the value of such a body as the Council to the medical profession and the pharmaceutical manufacturers as well as to the public. Of course this potential value cannot become effective as long as those concerned refuse to follow the Council in the use of new remedies.

Other noteworthy new drugs which appear in New and Nonofficial Remedies, 1938, are Avertin with Amylene Hydrate, Vinethene, Pontocaine Hydrochloride, basal, general and local anesthetics respectively; Novatropine and Syntropan, synthetic mydriatics.

Physicians who wish to know why a given proprietary is not described in New and Nonofficial Remedies will find the "Bibliographical Index to Proprietary and Unofficial Articles Not Included in N.N.R." of much value. In this section (in the back of the book) are given references to published articles dealing with preparations that have not been accepted. These include references to the Reports of the Council, to Reports of the A.M.A. Chemical Laboratory and to articles that have appeared in *The Journal*.

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AMONG OUR CONTRIBUTORS

Among Our Contributors

Dr. Emil Amberg was born in Santa Fe, New Mexico. He graduated from the University of Heidelberg, Germany, and was granted the license to practice medicine in Germany in 1894. His thesis for the doctor's title was written under the guidance of Professor Kraepelin. It led to the discovery of the "Warming-Up-Effect." He was interne in the Ear Department of the Massachusetts Charitable Eye and Ear Infirmary, Boston, Massachusetts, from January, 1896, to April, 1897. He is connected with several institutions in Detroit in his capacity as otologist.

* * *

Dr. James B. Blashill was graduated from the University of Michigan in 1927 with an A.B. degree and in 1930 with the M.D. He was associated with Dr. R. L. Fisher as resident in medicine and with Dr. Alexander Blain as resident in surgery at the Alexander Blain Hospital. Dr. Blashill has been in private practice in Detroit since 1933.

* * *

Dr. Willis L. Dixon is a graduate of Loyola University, 1916. He holds the position of consulting pediatrician, St. Mary's Hospital, Grand Rapids, Michigan, at the present time.

* * *

Dr. Charles H. Frantz is a graduate of the University of Michigan, 1932. He served his internship at Blodgett Memorial Hospital, 1932, was orthopedic resident, Blodgett, 1933; pathology resident, University of Michigan Hospital, 1934, and orthopedic resident, Blodgett Hospital, 1935. He is associated with Dr. John T. Hodgen in practice.

* * *

Dr. E. E. Hammonds was graduated from Washington University in 1934. He is now in private practice limited to internal medicine, in Birmingham, Michigan.

* * *

Dr. Edwin W. Hirsch of Chicago is a graduate of the University of Chicago, 1914, and of the Rush Medical College, 1916. He is attending Urologist at the Englewood Hospital, and Associate Urologist at the Mt. Sinai Hospital, Chicago. Dr. Hirsch limits his practice to Urology.

* * *

Dr. Sumner L. Koch of Chicago is a graduate of the Northwestern University Medical School, class of 1914. He is Associate Professor of Sur-

gery, Northwestern University Medical School and attending surgeon of the Passavant Memorial and Cook County Hospitals.

* * *

Dr. Earl G. Krieg of Detroit was graduated from Wayne University Medical School in 1925. He is instructor at the Wayne University Medical School, Junior Associate Surgeon in Gynecology at Receiving Hospital, Junior Attending Surgeon at Woman's Hospital, and Associate Attending Surgeon at the Alexander Blaine Hospital.

* * *

Dr. Louis D. Stern of Detroit received his A.B. degree from the University of Michigan in 1912, and M.D. in 1916. He had a Fellowship in Hematology at the Harvard Medical School, 1920-21. From 1921 to 1926 he was Instructor in Internal Medicine at the University of Michigan Medical School. Dr. Stern is now in private practice, limiting his work to internal medicine, and is attending physician at the Deaconess Hospital and North End Clinic.

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"Yep," answered Farmer Cornlossel, "I don't blame him. Everybody feels occasionally like gettin' away an' lookin' fur work 'stid o' stayin' where he knows it'll be waitin' for him regular."

Author, Author!

Housewife: "How did you come to fall so low as to go around the country begging?"

Tramp: "It's a long story, mum, and it's now in the hands of my publishers. I'm on my way to New York to correct the proofs."

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